

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

**Division of Behavioral Health Services
Medicaid Division**

BEHAVIORAL HEALTH AND MEDICAID

Adult Mental Health System

- **Service Definitions**
- **Utilization Guidelines**

Adult Substance Abuse System

- **American Society of Addiction Medicine (ASAM)**
- **Patient Placement Criteria**
- **Service Definitions**

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Note

Levels of Care and Placement Criteria adapted by permission of the publisher from Mee-Lee D, Shulman G, Fishman M, Gastfriend D & Harris JG, eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R), Chevy Chase, MD; American Society of Addiction Medicine. Copyright 2001. All rights reserved.

**BEHAVIORAL HEALTH
AND MEDICAID MANAGED CARE**

**Mental Health
Service Definitions
and
Utilization Guidelines**

**Acute Psychiatric Inpatient
SubAcute Psychiatric Inpatient
Crisis Stabilization
Partial Hospitalization
Day Treatment
Intensive Outpatient – MH
Medication Management
23/59 Observation
Assertive Community Treatment
Psychiatric Res. Rehabilitation
Day Rehabilitation
Community Support – MH
Intermediate Specialized Services**

Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
ACUTE INPATIENT	
Service Name	Psychiatric Hospital or General Hospital w/ Psychiatric Unit
Setting	Hospital
Facility license	Medically necessary, intensive, psychiatric facility based service
Basic definition	Purpose is to stabilize acute psychiatric conditions Locked facilities Serves persons with high to moderate risk of harm to self/others
Services	Multidisciplinary biopsychosocial assessments and multimodal treatments, including, but not limited to initial diagnostic interview by psychiatrist within 24 hours, history and physical within 24 hours, alcohol and drug assessment Structured treatment environment Modalities include: medical treatment, psychiatric care, psychopharmacology. Capacity to serve mentally ill & dangerous consumers & involuntary admissions
Commitment Requirements (for BH Division contractors)	Upon discharge, report completion of treatment to Mental Health Board Education for diagnosis/treatment/relapse, life skills Individual/Group/Family therapy Consultation on general medical, psychopharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic services, nursing, social work as well as overall program design. Treatment Plan within 24 hours Treatment Plan adjusted daily Consumer seen by the psychiatrist 6 out of 7 days May use physical/mechanical restraint & seclusion Relapse / crisis prevention plan is part of discharge plan Assessments & treatment must integrate strengths & needs in both MH/SA domains Meet accrediting body standards and, for NMMCP, CMS standards Discharge plan must be specific, individualized and begin at admission Typically 1 to 4 days, as long as medically necessary 24/7 skilled nursing
Length of Stay	24/7 skilled nursing
Staffing	Supervising Practitioner (Psychiatrist), licensed psychologist, program director (APRN, RN w/Master's in Psych. Nursing/counseling or related field, LMHP), psychiatric nursing, LMHP, case manager, recreational therapist, LADAC, psychiatric technicians
Hours of Operation	24/7
Consumer Need	Indications of actual/potential danger to self/others Indications of suicide/homicide ideation/gesture/attempt Does not require acute medical care Ability to respond to therapeutic intervention DSM (current version) (Axes I-V) diagnosis Increased functional deficits (from baseline) in areas of social, occupational, educational, interpersonal, self care domains Includes all persons who are in acute exacerbation of illness, including individuals with severe and persistent mental illness (SPMI)
Consumer Outcome	Acute psychiatric symptoms stabilized and individual no longer meets guidelines for acute care Precipitating condition and relapse potential stabilized Requires less than daily treatment plan adjustment Moderate to high risk of harm to self or others Moderate to high symptomatology Supports in place and can move to less restrictive treatment Treatment plan goals and objectives substantially met
Rate	NMMCP: See Medicaid rate schedule 1 unit = 1 day BH: See Behavioral Health rate schedule 1 unit = 1 day

Utilization Guidelines

ACUTE INPATIENT

ADMISSION GUIDELINES

Valid principal DSM (most current version) Axis I or II diagnosis AND at least one of the following:

1. Danger to self, as a product of the principal DSM diagnosis, as evidenced by any of the following:
 - a. Attempts to harm self that are life threatening or could cause disabling permanent damage with continued imminent risk.
 - b. Specific plan to harm self with clear intention, high lethality and availability of means.
 - c. A level of suicidality that cannot be safely managed at a less restrictive level of care.
 - d. Suicidality accompanied by rejection or lack of available social/therapeutic supports.
2. Danger to others, as a product of the principal DSM diagnosis, as evidenced by any of the following:
 - a. Life-threatening action with continued imminent risk.
 - b. Specific plan with clear intention, high lethality, and availability of means.
 - c. Dangerousness accompanied by a rejection or lack of available social/therapeutic supports.
3. Behaviors/symptoms that historically have been a prodrome to harm self/others and services/supports to avert the need for acute hospitalization are not available via coordination efforts.
4. Acute inability to care for self, secondary to a mental health disorder which is accompanied by gaps in psychosocial resources which would restore and/or maintain self care.
5. Required inpatient medical supervision for the treatment of a mental health disorder because of life-threatening, complicating medical factors.
6. Severe or life-threatening side effects of atypical complexity from using therapeutic psychotropic drugs.

EXCLUSIONARY GUIDELINES

Any of the following guidelines is sufficient for exclusion:

1. The individual can be safely maintained and effectively treated at a less intensive level of care.
2. Symptoms result from a medical condition that warrants a medical/surgical setting.
3. The individual exhibits serious and persistent mental illness and is NOT in an acute exacerbation of the illness.
4. The primary problem is social, economic (e.g. housing, family conflict, etc.) or one of physical health without a concurrent major psychiatric episode meeting guidelines for this level of care, or admission is being used as an alternative to incarceration.

CONTINUED STAY GUIDELINES *(must meet 1,2,3, AND Either 4 or 5)*

1. Valid DSM (most current version) Axis I or II diagnosis which remains the principal diagnosis.
2. The reasonable likelihood of substantial benefit as a result of medical intervention that necessitates the 24 hour inpatient setting.
3. Consumer unable to make progress towards goals or actively participate in treatment interventions due to the severity of clinical symptoms.
4. Continuation of symptoms or behaviors that required admission and the judgement that a less intensive level of care would be insufficient to stabilize the consumer's condition.
5. Appearance of new impairments meeting admission guidelines.

DISCHARGE GUIDELINES

Any of the following guidelines is sufficient for discharge:

1. Treatment plan goals and objectives have been substantially met.
2. The individual no longer meets admission guidelines or meets guidelines for a less intensive level of care.
3. Support systems that allow the consumer to be maintained in a less restrictive environment have been secured.
4. The consumer's physical condition necessitates transfer to a medical facility.

Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
SUBACUTE INPATIENT	
Service Name	Psychiatric Hospital or General Hospital w/ Psychiatric Unit
Setting	Hospital or mental health center license
Facility license	Serves persons with high to moderate risk for harm to self/others.
Basic definition	Purpose is to provide further stabilization, engage consumer in treatment, rehabilitation & recovery activities & transitions consumer to least restrictive setting as rapidly as possible Capacity to be locked facility
Services	Multidisciplinary biopsychosocial assessments and multimodal treatments, including, but not limited to initial diagnostic interview by psychiatrist within 24 hours, history and physical within 24 hours, alcohol and drug assessment Case Management (contact w/current community providers & family or other supports) Medication management by psychiatrist Psychological testing
Commitment Requirements (for BH Division contractors)	Capacity to serve mentally ill & dangerous consumers & involuntary admissions Upon discharge, report completion of treatment to Mental Health Board Education for diagnosis/treatment/relapse, life skills - 7 days/week active programming - minimum 42 hrs. (educational, pre-vocational, psycho-social skill building, nutrition, daily living skills, relapse prevention skills) Individual/Group/Family therapy
Programming	Consultation on general medical, psychopharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic services, nursing, social work as well as overall program design. Addictions treatment, if appropriate, initiated and integrated Treatment Plan within 24 hours Treatment Plan adjusted weekly or as medically indicated Interdisciplinary treatment team meetings/generally weekly treatment plan adjustment May use physical/mechanical restraint or locked time out rooms Relapse / crisis prevention plan is part of discharge plan Assessments & treatment must integrate strengths & needs in both MH/SA domains Meet accrediting body standards and, for NMMCP, CMS standards Behavioral management
Length of Stay	Discharge plan must be specific, individualized and begin at admission Average Length of Stay of 21 days, as long as medically necessary 24/7 skilled nursing - psychiatric
Staffing	Supervising Practitioner (Psychiatrist), licensed psychologist, program director (APRN, RN w/Master's in Psych. Nursing/counseling or related field, LMHP), psychiatric nursing, LMHP, case manager, recreational therapist, LADAC, psychiatric technicians
Hours of Operation	Access to MH professional on 24/7 basis 24/7
Consumer Need	Consumer can benefit from longer-term stabilization, treatment & rehabilitation setting Moderate to high risk of harm to self/others Active symptomology consistent with DSM (current version) (Axes I-V) diagnoses Ability to respond to intensive, structured intervention Moderate to high risk of relapse or symptom reoccurrence High need for professional structure & intervention Can be treated with short-term intensive intervention services Treatment/rehabilitation plan goals/objectives substantially met
Consumer Outcome	Precipitating condition and relapse potential stabilized for management at lower level of care Relapse / crisis prevention plan in place Support systems in place to be maintained in less restrictive setting
Rate	NMMCP: See Medicaid rate schedule 1 unit = 1 day BH: See Behavioral Health rate schedule 1 unit = 1 day

Utilization Guidelines

SUBACUTE INPATIENT PSYCHIATRIC SERVICE

ADMISSION GUIDELINES

Valid principal DSM (most current version) Axis I or II diagnosis, ability to make progress towards goals and actively participate in treatment interventions AND at least one of the following:

1. Danger to self, as a product of the principal DSM diagnosis, as evidenced by any of the following:
 - a. Attempts to harm self, which are life-threatening or could cause disabling permanent damage with continued risk without 24-hour psychiatric supervision.
 - b. Specific plan to harm self with clear intention, high lethality and availability of means. Suicidal ideation continues with plan and availability of means without 24-hour supervision.
 - c. A level of suicidality that cannot be safely managed at a less restrictive level of care.
 - d. Suicidality accompanied by rejection or lack of available social/therapeutic supports.
2. Danger to others, as a product of the principal DSM diagnosis, as evidenced by any of the following:
 - a. Life-threatening action with continued risk without 24-hour supervision.
 - b. Harmful ideation towards others continues with plan and availability of means without 24-hour supervision.
 - c. Dangerousness accompanied by a rejection or lack of available social/therapeutic supports.
3. Behaviors/symptoms that historically have been a prodrome to harm self/others and services/supports to avert the need for subacute hospitalization are not available via coordination efforts.
4. Acute inability to care for self, secondary to a mental health disorder, which is accompanied by gaps in psychosocial resources which would restore and/or maintain self care.
5. Required inpatient medical supervision for the treatment of a mental health disorder because of complicating medical factors.

EXCLUSIONARY GUIDELINES

Any of the following guidelines is sufficient for exclusion:

1. The individual can be safely maintained and effectively treated at a less intensive level of care.
2. Symptoms result from a medical condition that warrants a medical/surgical setting.
3. The individual exhibits serious and persistent mental illness and is NOT in an acute exacerbation of the illness.
4. The primary problem is social, economic (e.g. housing, family conflict, etc.) or one of physical health without a concurrent major psychiatric episode meeting guidelines for this level of care, or admission is being used as an alternative to incarceration.

CONTINUED STAY GUIDELINES (*must meet 1,2,3 And Either 4 or 5*)

1. Valid DSM (most current version) Axis I or II diagnosis which remains the principal diagnosis.
2. The reasonable likelihood of substantial benefit as a result of medical interventions that necessitates the 24-hour secure inpatient care setting.
3. Consumer able to make progress towards goals or actively participate in treatment interventions.
4. Continuation of symptoms or behaviors that required admission, and the judgement that a less intensive level of care would be insufficient to stabilize the consumer's condition.
5. Appearance of new impairments meeting admission guidelines.

DISCHARGE GUIDELINES

Any of the following guidelines is sufficient for discharge:

1. Treatment plan goals and objectives have been substantially met.
2. The individual no longer meets admission guidelines or meets guidelines for a less intensive level of care.
3. Support systems that allow the consumer to be maintained in a less restrictive environment have been secured.
4. The consumer's physical condition necessitates transfer to a medical facility.

Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
CRISIS STABILIZATION - Emergency Service	
Service Name	Facility based
Setting	Hospital, Mental Health Center
Facility license	24 hr. assessment, observation & supervision
Basic definition	Includes EPC admissions for BH contractors
	Locked facilities
Services	Emphasis of service is on crisis intervention, stabilization & psychiatric triage activities
	Multidisciplinary biopsychosocial assessments and multimodal treatments, including, but not limited to initial diagnostic interview by psychiatrist within 24 hours, history and physical within 24 hours, alcohol and drug assessment
	Crisis intervention & stabilization
	Case Management (contact w/current community providers & family or other supports)
Commitment Requirements (for BH Division contractors)	Medication management by psychiatrist
	Capacity to serve involuntary admissions (EPC)
Programming	Treatment plan within 24 hours
	Individual therapy daily
	Group therapy
	Family therapy daily, when appropriate
	Discharge plan begins at admission & includes referral & transition to next LOC, support services in community & anticipated Length of Stay
	Treatment team meetings with supervising practitioner (psychiatrist) present
	Psychiatrist provides face to face service 2 out of 3 days
	Relapse / crisis prevention plan is part of discharge plan
	Assessments & treatment must integrate strengths & needs in both MH/SA domains
	Meet accrediting body standards and, for NMMCP, CMS standards
	May use physical/mechanical restraint or locked time out rooms
	Consultation on general medical, psychopharmacology, psychological, dietary, emergency medical, laboratory and other diagnostic services as well as overall program design.
Length of Stay	Typically 1-5 days, as medically necessary (EPC statutes applicable where appropriate)
Staffing	24/7 skilled nursing
	Supervising Practitioner (Psychiatrist), licensed psychologist, program director (APRN, RN w/Master's in Psych. Nursing/counseling or related field, LMHP), psychiatric nursing, 1 RN/shift, therapists/counselors from the fields of (PhD, PPhD, LMHP, PLMHP, LADAC, PLADAC), case manager, psychiatric technicians
Hours of Operation	Access to dietary, emergency medical, lab, pharmacy, pastoral, psychological and other diagnostic services
	Open 24/7 for admissions
Consumer Need	Benefit from short-term, intensive, structured stabilization & intervention setting
	Significant incapacitating disturbance in mood/thought interfering with activities of daily living (ADLs)
	Active symptomology consistent with DSM (current version) (Axes I-V) diagnoses
	Assessment indicates sudden decompensation w/potential danger to self/others (not imminent dangerousness)
Consumer Outcome	Requires 24 hour observation and assessment
	For BH - Age 19 and older. For NMMCP - Age 21 and older.
	Triage, crisis intervention treatment plan goals/objectives substantially met
	Precipitating condition and relapse potential stabilized
Rate	Needs can be met with less or more intensive LOC
	Supports in place and can move to less restrictive treatment
	NMMCP: See Medicaid rate schedule 1 unit = 1 day
	BH: See Behavioral Health rate schedule 1 unit = 1 day

Utilization Guidelines

CRISIS STABILIZATION

ADMISSION GUIDELINES

All of the following guidelines are necessary:

1. The individual demonstrates a significant incapacitating or debilitating disturbance in mood/though interfering with Activities of Daily Living (ADLs) to the extent that immediate stabilization is required.
2. Demonstrates active symptomatology consistent with a DSM (most current version) (Axes I-V) diagnosis which requires and can reasonably respond to intensive, structured intervention.
3. Clinical evaluation indicates dramatic and sudden decompensation with a strong potential for danger (but not imminently dangerous) to self or others and has no available supports to provide continuous monitoring. Individual requires 24-hour observation and supervision.
4. Clinical evaluation indicates that the individual can be effectively treated with short-term intensive crisis intervention services and returned to a less intensive level of care within a brief time frame.
5. A less intensive or restrictive level of care has been considered/tried or clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care.

EXCLUSIONARY GUIDELINES

Any of the following are sufficient for exclusion from this level of care:

1. The individual's psychiatric condition is of such severity that it can only be safely treated in an acute or subacute inpatient setting.
2. The individual's medical condition is such that it cannot be safely treated in any setting other than a medical hospital.
3. The individual can be safely maintained and effectively treated at a less intensive level of care.
4. The primary problem is social, economic, or one of physical health without a concurrent major psychiatric episode meeting admission guidelines for this level of care, or admission is being used as an alternative to incarceration.

CONTINUED STAY GUIDELINES

All of the following are necessary for continuing treatment at this level of care:

1. Condition continues to meet admission guidelines.
2. Treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. Care is rendered in a clinically appropriate manner and focused on behavioral and functional outcomes as described in the discharge plan.
4. Treatment plan is individualized and appropriate to the consumer's changing condition with realistic and specific goals for this level of care.
5. All intervention and stabilization services and treatment are specifically and carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
6. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
7. There is documented active discharge, relapse and crisis prevention planning.

DISCHARGE GUIDELINES

Any of the following may be sufficient for discharge from this level of care:

1. Documented treatment plan goals and objectives have been substantially met.
2. The individual no longer meets continued stay guidelines or meets guidelines for a less or more intensive level of care.
3. Consent for treatment is withdrawn, and it has been determined that the individual has the capacity to make an informed decision.
4. Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured.

Service Definitions	
MEDICAID MANAGED CARE (NMMCP) - Currently not covered by BH	
PARTIAL HOSPITALIZATION	
Service Name	May or may not be hospital based
Setting	Mental Health Center, Hospital
Facility license	Clinical diagnostic and treatment services equivalent to inpatient but less than 24 hour basis. May be used to transition to/from inpatient hospitalization or residential LOC or as an alternative to hospitalization or residential LOC
Basic definition	Multidisciplinary biopsychosocial assessments and multimodal treatments, including, but not limited to initial diagnostic interview by psychiatrist within 24 hours, history and physical within 24 hours, alcohol and drug screening and assessment as indicated
Services	Structured treatment environment Modalities include: medical treatment, psychiatric care, psychopharmacology, medication management All services must be medically necessary
Commitment Requirements (for BH Division contractors)	Not applicable
Programming	Treatment plan completed within 24 hours
	Treatment plan reviewed weekly
	Minimum of 5 hours of active treatment per day within a structured milieu (exclusive of psychoeducation and support groups)
	Meet accrediting body standards and CMS standards
	Psychiatrist provides face to face service 4 out of 5 days
	May use physical restraint or seclusion
	Medication management
	Relapse / crisis prevention plan is part of discharge plan
	Consultation on general medical, psychopharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic services, nursing and social work
	Discharge plan must be specific, individualized and begin at admission
Length of Stay	Assessments & treatment must integrate strengths & needs in both MH/SA domains
	Average Length of Stay is 2 weeks
	Supervising Practitioner (Psychiatrist), licensed psychologist, program director (APRN, RN w/Master's in Psych. Nursing/counseling or related field, psychiatric technicians, LMHP and LADAC
Staffing	Nursing available at all times
Staff to Client Ratio	Minimum direct care staff is 1:3. Minimum therapist to consumer is 1:8.
Hours of Operation	Minimum 3 hours (half day) or 6 hours (full day). May be available 7 days/week. Minimum 5 days/week.
Consumer Need	Requires comprehensive multidisciplinary, multimodal treatment including medical and nursing observation/supervision to regulate medication and minimize risk to self/others
	Needs less than 24 hour inpatient setting
	DSM (current version) (Axes I-V) diagnosis
	Ability to respond to therapeutic intervention
	Capacity & support for reliable attendance
	Adequate social support system
Consumer Outcome	Risk of harm to self/others can be maintained with less than 24 hour medical/nursing supervision and observation but requires structure and supervision
	Treatment plan goals/objectives substantially met
	Support systems secured to maintain client is less restrictive level of care
Rate	Risk of harm to self/others can be maintained with less than 24 hour structure and medical/nursing supervision
	NMMCP: 1 unit = Full day (6 hrs), 1/2 unit = Half day (minimum 3 hrs)
	BH: Not Applicable

Utilization Guidelines

PARTIAL HOSPITALIZATION

ADMISSION GUIDELINES

Valid principal DSM (most current version) Axis I or II diagnosis AND All of the following:

1. The client is unable to maintain an adequate level of functioning outside the treatment program due to a mental health disorder as evidenced by:
 - a. Severe psychiatric symptoms
 - b. Inability to perform the activities of daily living
 - c. Failure of social/occupational functioning or failure and/or absence of social support resources.
2. The treatment necessary to reverse or stabilize the client's condition requires the frequency, intensity and duration of contact provided by a day program as evidenced by:
 - a. Failure to reverse/stabilize with less intensive treatment that was accompanied by services of alternative delivery systems.
 - b. Need for a specialized service plan for a specific impairment.
 - c. Passive or active opposition to treatment and the risk of severe adverse consequences if treatment is not pursued.
3. The client's medical and mental health needs can be adequately monitored and managed by the staff of the facility.

EXCLUSIONARY GUIDELINES

Any of the following are sufficient for exclusion from this level of care:

1. The individual is an active or potential danger to self or others or sufficient impairment exists that a more intense level of service is required.
2. The individual has medical conditions or impairments that warrant a medical/surgical setting for treatment.
3. The individual requires a level of structure and supervision beyond the scope of the program.
4. The individual can be safely maintained and effectively treated at a less intensive level of care.
5. The primary problem is social, economic (i.e. housing, family conflict, etc.) or one of physical health without a concurrent major psychiatric episode meeting guidelines for this level of care, or admission is being used as an alternative to incarceration.

CONTINUED STAY GUIDELINES

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual's condition continues to meet admission guidelines for this level of care.
2. The individual does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
4. The consumer is making progress toward goals and is actively participating in the interventions.
5. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
6. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner consistent with sound clinical practice, including evaluating and/or prescribing appropriate psychopharmacological intervention.
7. There is documented active discharge planning, including active relapse and crisis prevention planning.

DISCHARGE GUIDELINES

Any of the following may be sufficient for discharge from this level of care:

1. The individual's documented treatment plan, goals and objectives have been substantially met.
2. The individual no longer meets Continued Stay Guidelines, or meets Guidelines for a less or more restrictive level of care.
3. Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured.

Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
Service Name	DAY TREATMENT
Setting	May or may not be hospital based
Facility license	Mental Health Center, Hospital
Basic definition	Medically supervised alternative to psychiatric short-term inpatient services. Provides coordinated set of individualized therapeutic services to persons who may be able to function in a normal school, work and/or home environment but are in need of therapeutic supports. May be used as transition from higher LOC or for those at risk of being admitted to a higher LOC.
Services	Intensive primary and secondary assessments and treatment planning, but not limited to initial diagnostic interview by psychiatrist/psychologist within 24 hours, history and physical within 24 hours, alcohol and drug assessment, rehabilitation readiness assessment, functional assessment
	Structured treatment environment
	Modalities include: medical treatment, psychiatric care, psychopharmacology.
	Integrated substance abuse treatment, if appropriate
	Transitional support services
	Capacity to serve involuntary admissions
Commitment Requirements (for BH Division contractors)	Upon discharge, report completion of treatment to Mental Health Board
	BH: Minimum 6 hours / day, 5 days / week. NMMCP: Minimum 3 hours / day, 5 days / week.
	NMMCP: Initial diagnostic by supervising practitioner within 24 hrs. of admission
	Initial treatment plan within 24 hours
	Treatment plan reviewed every 2 wks (incorporates multidisciplinary assessments)
	Supervising practitioner sees consumer in face to face at least once per week but is present on a regular schedule and is clinically responsible for all treatment
	Treatment team meetings (supervising practitioner present every 2 weeks)
	May use physical restraint or seclusion
Programming	Consultation on general medical, psychopharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic services, nursing, social work as well as overall program design.
	Individual/family/group therapy
	Relapse / crisis prevention plan is part of treatment and discharge plan
	Programming shall include, but not limited to: crisis prevention, substance abuse prevention, social skill/relationship skill building, life skills building, medication education
	Meet accrediting body standards and, for NMMCP, CMS standards
	Discharge plan must be specific, individualized and begin at admission
Length of Stay	Average Length of Stay is 3 months
Staffing	Access to MH professional on a 24/7 basis
	Supervising Practitioner (Psychiatrist, licensed clinical psychologist), program director (LMHP or nurse with psychiatric education), therapist (LMHP, PLMHP, RN w/Master's in psychiatric nursing).
Staff to Client Ratio	Minimum direct care staff 1:6. Minimum therapist to consumer 1:12.
Hours of Operation	24/7
	Requires more active treatment and hours of structure than available in traditional outpatient services
	Severity of symptoms resulting in significant interference with community or workforce (social, vocational and/or educational functioning) - significant interference in at least 1 functional area
Consumer Need	Moderate supervision to avoid risk of harm to self/others
	Exacerbation or persistence of long standing psychiatric disorder that impairs functioning
	DSM (current version) (Axes I-V) diagnosis that can respond to intervention and rehabilitation
	Capable of mastering more complex personal/interpersonal life skills
	High risk of relapse
	Has living situation providing adequate supports
Consumer Outcome	Treatment plan goals/objectives substantially met
	Behavioral symptoms have decreased where there is not immediate risk and which can be contained in less restrictive LOC including routine outpatient services
	Moderate to low risk of harm to self/others
	Moderate to low risk of relapse
Rate	NMMCP: 1 unit = consumer day - a minimum of 3 hours
	BH: 1 unit = consumer day - a minimum of 6 hours

Utilization Guidelines

DAY TREATMENT

ADMISSION GUIDELINES

Valid principal DSM (most current version) Axis I or II diagnosis AND All of the following:

1. The client is unable to maintain an adequate level of functioning outside the treatment program due to a mental health disorder as evidenced by:
 - a. Severe psychiatric symptoms that require medical stabilization.
 - b. Inability to perform the activities of daily living.
 - c. Significant interference in at least one functional area (Social, vocational/educational, etc.)
 - c. Failure of social/occupational functioning or failure and/or absence of social support resources.
2. The treatment necessary to reverse or stabilize the client's condition requires the frequency, intensity and duration of contact provided by a day program as evidenced by:
 - a. Failure to reverse/stabilize with less intensive treatment that was accompanied by services of alternative delivery systems.
 - b. Need for a specialized service plan for a specific impairment.
 - c. Passive or active opposition to treatment and the risk of severe adverse consequences if treatment is not pursued.
3. The client's medical and mental health needs can be adequately monitored and managed by the staff of the facility.

EXCLUSIONARY GUIDELINES

Any of the following are sufficient for exclusion from this level of care:

1. The individual is an active or potential danger to self or others or sufficient impairment exists that a more intense level of service is required.
2. The individual has medical conditions or impairments that warrant a medical/surgical setting for treatment.
3. The individual requires a level of structure and supervision beyond the scope of the program.
4. The individual can be safely maintained and effectively treated at a less intensive level of care.
6. The primary problem is social, economic (i.e. housing, family conflict, etc.) or one of physical health without a concurrent major psychiatric episode meeting guidelines for this level of care, or admission is being used as an alternative to incarceration.

CONTINUED STAY GUIDELINES

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual's condition continues to meet admission guidelines for this level of care.
2. The individual does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
4. The consumer is making progress toward goals and is actively participating in the interventions.
5. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
6. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner consistent with sound clinical practice, including evaluating and/or prescribing appropriate psychopharmacological intervention.
7. There is documented active discharge planning, including relapse and crisis prevention planning.

DISCHARGE GUIDELINES

Any of the following may be sufficient for discharge from this level of care:

1. The individual's documented treatment plan, goals and objectives have been substantially met.
2. The individual no longer meets Continued Stay Guidelines, or meets Guidelines for a less or more restrictive level of care.
3. Symptoms are stabilized.
4. Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured.

ACTIVITIES OF DAILY LIVING

The proficiencies which allow the individual to live successfully in a non-institutional setting such as personal hygiene, self-care, leisure skills, interpersonal skills, meal preparation and nutrition, development of natural support systems as well as other related areas required to live independently in the community. Identify baseline. Functional deficits are measurable.

Service Definitions	
MEDICAID MANAGED CARE (NMMCP) Currently not covered by BH. BH Equivalent is Day Treatment	
INTENSIVE OUTPATIENT - MH	
Service Name	Usually facility based, office, clinic, hospital or other appropriate outpatient setting
Setting	Licensing as state regulations may require
Facility license	Provides a coordinated set of individualized treatment services to persons who are able to function in a school, work and home environment but are in need of treatment services beyond traditional outpatient services. May be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care.
Basic definition	Multidisciplinary biopsychosocial assessments and multimodal treatments, including, but not limited to initial diagnostic interview by psychiatrist/psychologist prior to or at the time of admission into the program, including alcohol and drug screening & assessment
Services	Structured treatment environment Modalities include: individual/family/group therapy services Medical education & monitoring
Commitment Requirements (for BH Division contractors)	Not applicable
Programming	Minimum 2 hours/day. Minimum 3 days/week. Maximum of 5 days/week.
	Individual/Group/Family therapy
	Consultation on general medical, psychopharmacology, psychological issues
	Initial treatment plan within first 2 sessions of service
	Master treatment plan within 2 weeks.
	Treatment plan reviewed every 2 weeks
	Supervision practitioner must do a direct service with consumer every 2 weeks and is available on an "as needed" basis and is clinically responsible for all treatment
	Relapse / crisis prevention plan is part of discharge plan
	Assessments & treatment must integrate strengths & needs in both MH/SA domains
	Meet accrediting body standards and, for NMMCP, CMS standards
Length of Stay	Discharge plan must be specific, individualized and begin at admission
	Typically no longer than 3 months. As long as medically necessary.
Staffing	Access to licensed MH professional on a 24/7 basis
	Supervising Practitioner (Psychiatrist, licensed clinical psychologist), program director (APRN, RN w/Master's in Psych. Nursing/counseling or related field, psychologist), therapists/counselors from the fields of (PhD, PPhD, LMHP, PLMHP, LADAC)
Staff to Client Ratio	Therapist to client ratio of 1:12
Hours of Operation	Minimum 2 hours/day for a minimum of 3 days/week. Consumer maximum is 5 days/week. Program may be available 7 days/week.
Consumer Need	Requires more active treatment than available in traditional outpatient program service
	Severity of psychiatric symptoms resulting in significant interference with community, school, family or work performance
	Exacerbation or persistence of longstanding psychiatric disorder that impairs functioning
Consumer Outcome	Ability to respond to therapeutic intervention
	DSM (current version) (Axes I-V) diagnosis
	Treatment plan goals and objectives substantially met.
	Behavioral symptoms decreased
Rate	Able to remain stable with less intensive level of services, including routine outpatient services
	NMMCP: See Medicaid rate schedule - a minimum of 2 hours of services/day
	BH: Not applicable

Utilization Guidelines

INTENSIVE OUTPATIENT – MENTAL HEALTH – Adult

ADMISSION GUIDELINES

Valid principal DSM (most current version) Axis I or II diagnosis AND All of the following:

1. The individual's disorder can be expected to improve significantly through medically necessary and appropriate therapy.
2. The consumer is only able to maintain an adequate level of functioning outside the treatment program with this service intensity
3. Significant symptoms that interfere with the individual's ability to function in at least one life area.
4. The client's medical and mental health needs can be adequately monitored and managed by the staff of the facility.

EXCLUSIONARY GUIDELINES

Any of the following are sufficient for exclusion from this level of care:

1. The individual is an active or potential danger to self or others or sufficient impairment exists that a more intense level of service is required.
2. The individual has medical conditions or impairments that warrant a medical/surgical setting for treatment.
3. The individual requires a level of structure and supervision beyond the scope of the program.
4. The individual can be safely maintained and effectively treated at a less intensive level of care.
5. The primary problem is social, economic (i.e. housing, family conflict, etc.) or one of physical health without a concurrent major psychiatric episode meeting guidelines for this level of care, or admission is being used as an alternative to incarceration.

CONTINUED STAY GUIDELINES

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual's condition continues to meet admission guidelines for this level of care.
2. The individual does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
4. The consumer is making progress toward goals and is actively participating in the interventions.
5. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
6. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner consistent with sound clinical practice, including evaluating and/or prescribing appropriate psychopharmacological intervention.
7. There is documented active discharge planning, including relapse and crisis prevention planning.

DISCHARGE GUIDELINES

Any of the following may be sufficient for discharge from this level of care:

1. The individual's documented treatment plan, goals and objectives have been substantially met.
2. The individual no longer meets Continued Stay Guidelines, or meets Guidelines for a less or more restrictive level of care.
3. Symptoms are stabilized.
4. Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured.

Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
Service Name	MEDICATION MANAGEMENT
Setting	Office, clinic, hospital, or other appropriate outpatient setting. NMMCP: Include Telehealth and home settings.
Facility license	Mental Health Center, Substance Abuse Treatment Center, hospital
Basic definition	Evaluation, provision and monitoring of psychotropic medication and symptom management
Services	Psychiatrist, Psychiatric APRN, evaluation of need for psychotropic medication. BH: Include PA supervised by psychiatrist. Provision of prescriptions for psychotropic medications Ongoing medication monitoring
Commitment Requirements (for BH Division contractors)	Not applicable
Programming	Medication evaluation, checks and education as often as medically necessary
Length of Stay	As often as medically necessary, ongoing
Staffing	Psychiatrist, or other physician credentialed to evaluate and provide psychotropic medication, Psychiatric Advanced Practice Registered Nurse (APRN). BH: Include PA or NP supervised by psychiatrist or other physician credentialed to evaluate and provide psychotropic medication.
Staff to Client Ratio	1 to 1
Hours of Operation	May be 24 hours, generally clinic hours
Consumer Need	Requires control of symptomology related to psychiatric disorder with need for improved functioning
	BH: 1+ functional limitations (social, occupational, educational, interpersonal, self care)
	Determination and initiation of a treatment plan
	Assessment of re-emerging psychiatric symptoms or medication side effects
	DSM (current version) (Axes I-V) diagnosis
Consumer Outcome	Stabilization or resolution of psychiatric symptoms
	Improved functioning
	Treatment plan goals and objectives substantially met.
	No longer requires psychotropic medications
	Consent for treatment withdrawn
Rate	NMMCP: CPT code is based on occurrence NOT time limited. See Medicaid rate schedule.
	BH: See Behavioral Health rate schedule

Utilization Guidelines

MEDICATION MANAGEMENT

ADMISSION GUIDELINES

All are required:

1. Valid principal DSM (current version) diagnosis in Axis I or II
2. Need for prescribing and monitoring psychotropic medications

EXCLUSIONARY GUIDELINES

The individual would not benefit from psychotropic medication.

CONTINUED STAY GUIDELINES

Continues to meet admission guidelines.

DISCHARGE GUIDELINES

1. The individual no longer requires psychotropic medications.
2. The individual no longer meets Continued Stay Guidelines, or meets Guidelines for a less or more restrictive level of care.

Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
Service Name	23/59 Observation - Emergency Service
Setting	Facility based, hospital
Facility license	Mental Health Center, Hospital, Substance Abuse Treatment Center
Basic definition	Provides up to 23:59 hours of care in secure, protected, medically and psychiatrically supervised setting designed to assess an individual experiencing acute psychiatric OR substance abuse symptomology / condition. Provides prompt evaluation & stabilization.
	Multidisciplinary biopsychosocial assessment including but not limited to an initial diagnostic interview by psychiatrist within 23:59 hours of admission, including substance abuse screening
	Treatment plan with emphasis on crisis intervention and relapse prevention services
Services	Nursing, including medical screening
	Substance abuse assessment by LADAC, if indicated by screening
	Medication evaluation and management
	Psychiatric and psychological assessment
	Individual/group therapy
Commitment Requirements (for BH Division contractors)	Not applicable
Programming	Crisis observation, intervention & stabilization
	May use physical restraint or seclusion
	Consultation on general medical, psychopharmacology, psychological issues.
	Capacity to observe, serve involuntary admissions
	Discharge plan must be specific, individualized and begin at admission
Length of Stay	23:49 hours
Staffing	Skilled nursing 24/7
	Clinical supervision by fully licensed MH clinician
	BH: Physician on staff or under contract to assume clinical responsibility
	Consistent with accreditation
Staff to Client Ratio	24/7, 7 days per week
Hours of Operation	Indications of acute psychiatric or substance abuse symptomology or distress
Consumer Need	Symptoms consistent with DSM (current version) (Axes I-V) diagnoses and likely to respond to therapeutic intervention services
	Unclear clinical situation, uncertain as to service need, requires brief period of observation & assessment
	Does not meet acute criteria but has temporal change within timeframe
	Indications of actual/potential danger to self/others
	Abrupt and substantial change in functioning
	Medically stable
Consumer Outcome	Treatment plan goals and objectives substantially met.
	Length of stay surpasses 23:59 hours
	Support system allows consumer to be maintained at lesser LOC
	Consent for treatment withdrawn
Rate	BH: Consumer is placed under protective custody (EPC'd)
	NMMCP: 1-8 hours, 9-16 hours, 17-23:49 hours See Medicaid rate Schedule
	BH: See Behavioral Health rate schedule 1 unit = 1 day

Utilization Guidelines

23:59 EMERGENCY OBSERVATION, EVALUATION, HOLDING 9/22/04

ADMISSION GUIDELINES

All of the following are necessary for admission to this level of care:

1. The individual presents in a condition (intoxicated, agitated, depressed) that is likely to significantly change after a period of rest or observation.
2. The individual's medical needs are stable.
3. The individual does not meet all inpatient criteria, but it is assessed that a period of observation may assist in the stabilization/prevention of symptoms.
4. Based on current information, there is a lack of diagnostic clarity and further evaluation is necessary to determine the client's service needs.

EXCLUSIONARY GUIDELINES

Any of the following guidelines are sufficient for exclusion from this level of care:

1. Medically unstable.
2. Client may be served in a less or more intensive levels of care.
3. The primary problem is social, economic (i.e. housing, family conflict) or one of physical health, or admission is being used as an alternative to incarceration.

CONTINUED STAY GUIDELINES

There is no continued stay associated with 23-hour observation.

DISCHARGE GUIDELINES

Any of the following guidelines may be sufficient for discharge from this level of care:

1. Evaluation and stabilization goals and objectives have been substantially met.
2. The individual no longer meets admission guidelines.
3. Length of stay at this level of care has surpassed the program's maximum 23:59 hour length of stay.
4. Consent for treatment is withdrawn.

Service Definitions	
Service Name	BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)
Setting	ASSERTIVE COMMUNITY TREATMENT - MRO Service
Facility license	Community based setting, client's home. Minimal services provided in an office-based setting.
Basic definition	Not applicable Self contained clinical team which assumes clinical responsibility for directly providing comprehensive and integrated treatment, rehabilitation and support services to consumers with severe disability due to severe and persistent mental illness.
Services	Comprehensive, multidisciplinary biopsychosocial assessments- initial and ongoing
	Treatment Plan and crisis/relapse prevention plan within 21 days of assessment
	Crisis intervention and response
	Multidisciplinary integrated treatment, rehabilitation and support plan coordination
	Individualized treatment, rehabilitation and support interventions
	Medical assessment, management and intervention
	Individual/family/group psychotherapy or substance abuse counseling
	Medication (provide prescription, preparation, delivery, administration and monitoring)
	Psychoeducational services
	Rehabilitation services including symptom management, skill development (pre-vocational, daily living, social, interpersonal, leisure)
Commitment Requirements (for BH Division contractors)	Supportive interventions including direct assistance and coordination in obtaining basic necessities (medical, housing, social services, transportation, etc.), in vivo support on personal goals, family support/education and consultation, and positive peer role modeling
	Capacity to serve committed individuals who meet criteria
	Upon discharge, report completion of treatment to Mental Health Board
	Clinical supervision
	Daily treatment team meetings
	Ongoing assessment, treatment and service planning meetings
	Provision of service intensity to meet individualized consumer needs
	Crisis intervention and response
	Meets standards for national accreditation. Acquires and maintains accreditation.
	As long as medically necessary or agreed upon discharge between client & team
Length of Stay	Team psychiatrist (meets FTE standards/consumers served on team)
	Team Leader (Master's degree in nursing, social work, psychiatric rehabilitation, psychology), Psychiatrist, Physician's Assistant,
	Mental Health Professionals (minimum 1) - LMHP
	Registered Nurse
	Peer Support Worker
	MH Worker (dually licensed LMHP/LADAC, LADAC, BA in Psych. Rehabilitation) - LADAC preferred
	Additional staff: LMHP or RN or MH Worker
	Support Staff
	Team/client ratio of 1:70. Team member to client ratio 1:8
	24/7 including weekends, evenings, holidays. Minimum 12 hr/day, 8 hrs/day on weekends/holidays. On call.
Consumer Need	DSM (current version) (Axes I-V) diagnosis and disabled by severe and persistent mental illness
	History of high utilization of psychiatric inpatient and emergency resources
	Client has less than satisfactory response to previous levels of treatment intervention
	Ability to respond to therapeutic intervention
	High risk of relapse without the high intensity of services
Consumer Outcome	Treatment plan goals and objectives substantially met.
	Consent for treatment withdrawn
	Mutual discharge between client and team
	Supports in place and can move to less restrictive treatment
	BH: See Behavioral Health rate schedule 1 unit = 1 day
Rate	NMMCP: See Medicaid rate schedule 1 unit = 1 day

Utilization Guidelines

ASSERTIVE COMMUNITY TREATMENT

ADMISSION GUIDELINES

All of the following must be present:

1. DSM (current version) Axis I diagnosis consistent with a serious and persistent mental illness i.e. a primary diagnosis of schizophrenia, major affective disorder or other major mental illness under the current edition of DSM.
2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate manner in two of three functional areas.
3. Presence of functional deficits in two of three functional areas: Vocational/education, Social Skills, Activities of Daily Living.
 - a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
 - b. Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
 - c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in three of five of the following:
 1. Grooming, hygiene, washing clothes, meeting nutritional needs;
 2. Care of personal business affairs;
 3. Transportation and care of residence;
 4. Procurement of medical, legal, and housing services; or
 5. Recognition and avoidance of common dangers or hazards to self and possessions.
4. Functional deficits of such intensity requiring extensive professional multidisciplinary treatment, rehabilitation and support interventions with 24 hour capability.
5. The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed treatment and rehabilitation services are not provided.
6. The individual has a history of high utilization of psychiatric inpatient and emergency services.
7. The individual has had less than satisfactory response to previous levels of treatment and rehabilitation interventions.

EXCLUSIONARY GUIDELINES

Any of the following are sufficient for exclusion from this level of care:

1. The individual does not meet DSM (current version) Axis I diagnosis consistent with severe and persistent mental illness.
2. The individual has a primary diagnosis of substance dependence/abuse or developmental disability.
3. The persistent mental illness has not been present for the last 12 months or is not expected to last 12 months or longer.
4. The persistent mental illness does not seriously interfere with the client's ability to function independently in two of three functional areas.
5. The individual is a resident of a nursing facility or psychiatric residential rehabilitation facility.
6. The individual requires inpatient treatment services for a period exceeding 7 days.

CONTINUED STAY GUIDELINES

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual continues to meet admission guidelines.
2. The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. The individual is making progress towards treatment and rehabilitation goals.

DISCHARGE GUIDELINES

All of the following are required for discharge from this level of care:

1. Maximum treatment and rehabilitation benefit and goals have been achieved. The consumer can function independently without extensive professional multidisciplinary supports. (Deficits in daily living have improved. Deficits in functional areas have improved and now manageable without extensive supports.) Services are primarily monitor in nature and can be sustained with a lesser level of care.
2. Sustainability plan for supports is in place.
3. Formal and informal supports have been established.
4. A crisis relapse plan is in place.

OR The client requests discharge. OR The individual relocates out of the ACT team's geographic area. OR The consumer is admitted to a higher level of care (inpatient, residential levels of care) for a period to exceed 7 days.

Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
Service Name	PSYCHIATRIC RESIDENTIAL REHABILITATION - MRO Service
Setting	Facility-based, non-hospital or nursing facility
Facility license	Mental Health Center, residential care facility, assisted living facility
Basic definition	24-hr. psychiatric rehabilitation, support and supervision in a community setting for individuals disabled by severe and persistent mental illness and who are unable to reside in a less restrictive setting due to the pervasiveness of the impairment. Services are designed to increase functioning to enable successful living in the residential setting of choice, capabilities and resources, and decrease the frequency and duration of hospitalizations.
Services	Comprehensive mental health and substance abuse screening and/or evaluation prior to admission
	Strength-based psychosocial needs assessment within 30 days
	Rehabilitation and support plan within 30 days
	Discharge planning beginning at admission
	Supportive services, referral, problem identification/solution, service coordination
Commitment Requirements (for BH Division contractors)	Individual Service Plan developed with consumer
	Not applicable
Programming	Ongoing assessment
	Arranges for general medical, psychopharmacological and psychiatric services as necessary
	Minimum 25 hours/week of on-site psychosocial rehabilitation activities and skill acquisition
	Programming focused on relapse prevention, nutrition, daily living skills, social skill building, community living, substance abuse, medication education and self-administration, and symptom management
	Pre-vocational, educational and vocational focus as needed
Length of Stay	Minimum of 20 hours/week of additional off-site rehabilitation, vocational and educational activities. 6-18 months; average length of stay 12 months
Staffing	Program Manager (LMHP, psychologist, RN w/Master's in psychology, nursing or related field). Direct care staff w/Bachelor's degree or higher in psychology, sociology, related field or equivalent course work and two years experience in working with clients with mental illness or substance abuse issues.
Staff to Client Ratio	Appropriate staff coverage to provide services for clients remaining in the residence during the day.
Hours of Operation	Days: 1-4. Night hours 1:10 awake staff with on-call staff available. 24/7
Consumer Need	Moderate to severe symptomology related to DSM (current version) diagnosis identifying a severe and persistent mental illness
	Unable to reside in less restrictive residential setting and requires 24/7 supervision
	Moderate to high risk of relapse
	Moderate risk of harm to self/others
	Long-standing severe psychiatric functional disorder amenable to active rehabilitation and treatment
Consumer Outcome	High risk of rehospitalization without 24 hour supervision
	Risk for harm and relapse stabilized/contained to be managed at lesser level of care
	Increased functioning to allow successful residential living with less supervision
	Decrease in duration and frequency of psychiatric hospitalization
	Skill development can be sustained through supportive services
Rate	BH: See Behavioral Health rate schedule (excludes room and board) 1 unit = 1 day
	NMMCP: See Medicaid rate schedule (excludes room and board) 1 unit = 1 day

Utilization Guidelines

PSYCHIATRIC RESIDENTIAL REHABILITATION

ADMISSION GUIDELINES

All of the following must be present:

1. DSM (current version) Axis I diagnosis consistent with a serious and persistent mental illness i.e. a primary diagnosis of schizophrenia, major affective disorder or other major mental illness under the current edition of DSM.
2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate manner in two of three functional areas.
3. Presence of functional deficits in two of three functional areas: Vocational/education, Social Skills, and Activities of Daily Living.
 - a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
 - b. Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
 - c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in three of five of the following:
 1. Grooming, hygiene, washing clothes, meeting nutritional needs;
 2. Care of personal business affairs;
 3. Transportation and care of residence;
 4. Procurement of medical, legal, and housing services; or
 5. Recognition and avoidance of common dangers or hazards to self and possessions.
4. Functional deficits of such intensity requiring professional interventions in a 24 hour psychiatric residential setting.
5. The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed residential rehabilitation services are not provided.

EXCLUSIONARY GUIDELINES

Any of the following are sufficient for exclusion from this level of care:

1. The individual does not meet DSM (current version) Axis I diagnosis consistent with severe and persistent mental illness.
2. The individual has a primary diagnosis of substance dependence/abuse or developmental disability.
3. The persistent mental illness has not been present for the last 12 months or is not expected to last 12 months or longer.
4. The persistent mental illness does not seriously interfere with the client's ability to function independently in two of three functional areas.
5. The individual is authorized for ACT services.

CONTINUED STAY GUIDELINES

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual continues to meet admission guidelines.
2. The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. The individual is making progress towards rehabilitation goals.

DISCHARGE GUIDELINES

All of the following are required for discharge from this level of care:

1. Maximum benefit has been achieved.
2. The individual can function independently with supports outside of a 24-hour structured setting. (Deficits in daily living have improved. Deficits in functional areas have improved and now manageable without structured professional intervention.
3. Consumer can function such that she/he can live successfully in the residential setting of his/her choice.
4. Sustainability plan for supports is in place.
5. Formal and informal supports have been established.
6. A crisis relapse plan is in place.

OR The individual requests discharge from the service.

Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
DAY REHABILITATION - MRO Service	
Service Name Setting	Facility-based
Facility license	Mental Health Center, Adult Day Service
Basic definition	Rehabilitation and support services in a day program setting for persons disabled by severe and persistent mental illness. Individuals receive services designed to develop and maintain skills and functioning needed to successfully live in the community.
Services	Strength-based psychosocial needs assessment within 30 days
	Rehabilitation and support plan within 30 days
	Discharge planning beginning at admission
	Adult daily living skills development
	Social skills development through planned socialization and recreational activities
	Psycho-educational programming
	Skill-building is use of transportation and/or access to transportation
	Supportive services, referral, problem identification/solution, service coordination (primary coordination with all physicians and medical services)
	Pre-vocational services
	Individual service plan developed with consumer
Commitment Requirements (for BH Division contractors)	Relapse and crisis prevention plan
	Not applicable
Programming	Ongoing assessment
	Arranges for general medical, psychopharmacological and psychiatric services as necessary
	Services available minimum of 5 hours/day, 5 days/week including weekend and evening hours
	Programming focused on relapse prevention, nutrition, daily living skills, social skill building, community living, substance abuse, medication education and self-administration, and symptom management
	Pre-vocational, educational and vocational focus as needed
	Meet all food handling, storage and processing requirements as required by R&L
	Rehabilitation and treatment team meetings
	Weekly to monthly review/adjustment of treatment and rehabilitation plans to meet the medical and rehabilitative needs of each client
	16 to 24 months
	Clinical supervision (LMHP, psychologist, RN w/Master's degree in psychiatric nursing, psychology or related field.
Staffing	Direct care staff have minimum Bachelor's degree or post-high school coursework in psychology or related field and two years experience in the delivery of mental health services.
Staff to Client Ratio	Consultation by licensed professionals on general medical, dietary, chemical dependence, pharmacology and psychiatric issues.
	Direct care staff minimum 1:6
Hours of Operation	Regularly scheduled evening and weekend hours. Consumer has access to licensed mental health provider 24/7
	DSM (current version) identifying a severe and persistent mental illness
Consumer Need	2+ functional deficits expected to improve with skill development and interventions
	Moderate symptomology
	Low to moderate risk of harm to self/others
	Moderate risk of relapse
	Moderate need of professional structure
	Requires weekly to monthly treatment/rehabilitation plan adjustment
Consumer Outcome	Risk for harm and relapse stabilized/contained to be managed at lesser level of care
	Improvement in functional deficit areas
	Rehab plan goals and objectives substantially met
	Low risk of harm to self/others
	Low risk of relapse or contained with relapse plan
	Low need for professional structure
	Attendance is minimal
Rate	Skill development can be sustained through supportive services
	BH: 1 unit = Full day - 5 hours minimum, 1/2 unit = 1/2 Day - 3 hours minimum See Behavioral Health rate schedule
	NMMCP: 1 unit = Full day - 5 hours minimum, 1/2 unit = 1/2 Day - 3 hours minimum See Medicaid rate schedule

Utilization Guidelines

Day Rehabilitation – MH

ADMISSION GUIDELINES

All of the following must be present:

1. DSM (current version) Axis I diagnosis consistent with a serious and persistent mental illness i.e. a primary diagnosis of schizophrenia, major affective disorder or other major mental illness under the current edition of DSM.
2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate manner in two of three functional areas.
3. Presence of functional deficits in two of three functional areas: Vocational/education, Social Skills, and Activities of Daily Living.
 - a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
 - b. Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
 - c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in three of five of the following:
 1. Grooming, hygiene, washing clothes, meeting nutritional needs;
 2. Care of personal business affairs;
 3. Transportation and care of residence;
 4. Procurement of medical, legal, and housing services; or
 5. Recognition and avoidance of common dangers or hazards to self and possessions.
4. Functional deficits of such intensity requiring professional interventions in a structured day setting.
5. The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed rehabilitation services are not provided.

EXCLUSIONARY GUIDELINES

Any of the following are sufficient for exclusion from this level of care:

1. The individual does not meet DSM (current version) Axis I diagnosis consistent with severe and persistent mental illness.
2. The individual has a primary diagnosis of substance dependence/abuse or developmental disability.
3. The persistent mental illness has not been present for the last 12 months or is not expected to last 12 months or longer.
4. The persistent mental illness does not seriously interfere with the client's ability to function independently in two of three functional areas.
5. The individual is in an inpatient setting.
6. The individual is a resident of a nursing facility.

CONTINUED STAY GUIDELINES

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual continues to meet admission guidelines.
2. The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. The individual is making progress towards rehabilitation goals.

DISCHARGE GUIDELINES

All of the following are required for discharge from this level of care:

1. Maximum benefit has been achieved and consumer can function independently without extensive supports. (Deficits in daily living have improved. Deficits in functional areas have improved and now manageable without extensive supports.) Services are primarily monitor in nature. Consumer can function such that she/he can live successfully in the residential setting of his/her choice.
2. Sustainability plan for supports is in place.
3. Formal and informal supports have been established.
4. A crisis relapse plan is in place.

OR The individual requests discharge from the service.

Service Definitions	
Service Name	BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)
Setting	COMMUNITY SUPPORT - MENTAL HEALTH - MRO Service
Facility license	Community-based, most frequently provided in the home
Basic definition	Not facility-based Rehabilitative service for individuals disabled by severe and persistent mental illness. Skilled paraprofessionals provide direct rehabilitation and support services and interventions and assist in developing services necessary to maintain community living and prevent exacerbation of illness and admission to higher levels of care.
Services	Comprehensive strength-based psychosocial assessment within 30 days Collect information and develop Individual Program/Service Plan within 30 days Direct provision of active rehabilitation and support interventions with focus on: Activities of Daily Living, education, budgeting, medication compliance and self-administration, relapse prevention, social skills, and independent living skills. Participation in and reporting to treatment/rehabilitation team on the progress in areas of medication compliance, relapse prevention, social skill acquisition and application, education and substance use/abuse Service coordination and case management activities including coordination or assistance in accessing medical, social, education, housing, transportation, or other appropriate support services as well as linkage to more/less intensive community services. Crisis/relapse prevention plan Support and intervention in time of crisis. Crisis/relapse intervention and involvement to transition consumer's return to community and avoid need for higher levels of care Facilitate communication between treatment and rehabilitation providers and with primary/supervision practitioner Monitor medication compliance Not applicable
Commitment Requirements (for BH Division contractors)	Ongoing assessment Treatment, rehabilitation and program/service plan meetings Program/Service plan reviewed/updated every 30 days Frequency of face to face contacts based upon need - estimate minimum of 3 / month Access to CS worker for support, intervention, coordination during times of crisis Clinical supervision of individual service plans Service delivery NOT provided during same service delivery hour of other rehabilitation services Approved service provision, as transition, 30 days post-admission or 30 days pre-discharge from inpatient/residential LOC to decrease length of stay and support continuity of care Consultation by professionals licensed/credentialed by HHS on general medical, psychopharmacology, psychological issues, program design
Length of Stay	Average Length of Stay 12 months, as long as medically necessary
Staffing	Direct care workers: BS in psychology, social work or related field and minimum of one year experience in direct care of consumers with severe and persistent mentally illness or other MH services. Bachelor's degree in another field with advanced education in psychology, social work, sociology or other related fields or an Associate degree in human services or related field and have a minimum of two years experience in direct services to persons with severe and persistent mental illness or other MH services. Clinical supervision by licensed clinician with three to five years experience in the delivery of mental health and substance abuse rehabilitation services. Therapist provides direction and supervision of individual service/program plan
Staff to Client Ratio	Caseload 1:20
Hours of Operation	24/7. Access to service during weekend/evening hours or in time of crisis with MH provider backup.
Consumer Need	DSM(current version) identifying severe and persistent mental illness 2+ functional deficit areas expected to respond and improve with skill development and interventions Requires active skills development, assistance and support to maintain stable community living Medically and psychiatrically stable Sustained stable community living
Consumer Outcome	Rehab plan goals and objectives substantially met Crisis/relapse prevention plan implemented Consumer can sustain community living without active rehab interventions and supports
Rate	BH: See Behavioral Health rate schedules 1 unit = 1 month NMMCP: See Medicaid rate schedules 1 unit = 1 month

Utilization Guidelines

COMMUNITY SUPPORT – MH

ADMISSION GUIDELINES

All of the following must be present:

1. DSM (current version) Axis I diagnosis consistent with a serious and persistent mental illness; i.e. a primary diagnosis of schizophrenia, major affective disorder or other major mental illness under the current edition of DSM.
2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate manner in two of three functional areas.
3. Presence of functional deficits in two of three functional areas: Vocational/education, Social Skills, and Activities of Daily Living.
 - a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
 - b. Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
 - c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in three of five of the following:
 1. Grooming, hygiene, washing clothes, meeting nutritional needs;
 2. Care of personal business affairs;
 3. Transportation and care of residence;
 4. Procurement of medical, legal, and housing services; or
 5. Recognition and avoidance of common dangers or hazards to self and possessions.
4. Client is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed rehabilitation services are not provided.

EXCLUSIONARY GUIDELINES

Any of the following are sufficient for exclusion from this level of care:

1. The individual does not meet DSM (current version) Axis I diagnosis consistent with severe and persistent mental illness.
2. The individual has a primary diagnosis of substance dependence/abuse or developmental disability.
3. The persistent mental illness has not been present for the last 12 months or is not expected to last 12 months or longer.
4. The persistent mental illness does not seriously interfere with the client's ability to function independently in two of three functional areas.
5. The individual is in an inpatient or psychiatric residential rehabilitation setting and is not within 30 days post-admission and 30 days pre-discharge from these levels of care.
6. The individual is authorized for ACT services.
7. The individual is a resident of a nursing facility.

CONTINUED STAY GUIDELINES

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual continues to meet admission guidelines.
2. The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. The individual is making progress towards rehabilitation goals.

DISCHARGE GUIDELINES

All of the following are required for discharge from this level of care:

1. Maximum benefit has been achieved and consumer can function independently without extensive supports. (Deficits in daily living have improved. Deficits in functional areas have improved and now manageable without extensive supports.) Rehabilitation goals have been substantially achieved and the consumer can function independent of active supports. Services are primarily monitoring in nature.
2. Sustainability plan for supports is in place.
3. Formal and informal supports have been established.
4. A crisis relapse plan is in place.

OR The individual requests discharge from the service.

Service Definitions		
Service Name	BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
Setting	INTERMEDIATE SPECIALIZED SERVICES - NURSING FACILITY - Medicaid Covered Service Only	
Facility License	General expectation is unit within an existing nursing facility Nursing facility license Maximum capacity: 16 bed facility or unit.	
Basic Definition	Nursing facility services for individuals with serious mental illness requiring additional services necessary to prevent avoidable physical and mental deterioration and to assist clients in obtaining or maintaining their highest level of functional and psycho-social well being. Services are designed to decrease the frequency and duration of hospitalization and inpatient psychiatric services and promote stabilization with discharge to independent living or basic nursing facility level of care. Without this service the consumer would be served in an inpatient psychiatric facility.	
Services	Initial Care Plan within 24 hours of admission	
	Psychiatrist sees consumer within 24 hours of admission	
	On-site medical review (face to face) with consumer twice per month by psychiatrist	
	Psychiatrist sign off on all care plans	
	Comprehensive Care Plan completed by interdisciplinary (physical and behavioral health care staff) within 14 days of admission	
	Care plans are updated quarterly or as needed upon change in consumer status	
	Discharge plan as part of care plan - specific and individualized	
	Structured treatment and rehabilitation services	
	Medication management	
	Case Management	
Programming	Psychosocial Services	
	Recreational services	
	Outreach	
	Meet regular NF regulatory requirements	
	Not applicable	
	Interdisciplinary team (psychiatrist, social work, nursing (general medical and psychiatric), and other qualified mental health provider(s))	
	Psychiatrist available pm 24/7	
	Crisis Intervention	
	Prevention / Intervention	
	Physical management procedures	
Length of Stay	Behavioral management	
	De-escalation procedures	
	Initial and ongoing biopsychosocial assessment	
	Psychosocial Skill Development	
	Rehab and treatment team meetings	
	Secure environment	
	Ability to provide restraint and seclusion (physical and/or mechanical) per existing nursing facility criteria	
	Telemedicine capabilities	
	As long as medically necessary	
	Psychiatrist available 24/7 (geriatric psychiatric preferred)	
Staffing	Psychiatric RN, Nursing Staff to Client ratio: 1 to 6	
	Psychiatric paraprofessionals	
	Behavioral Psychologist available for consultation	
	Social work	
	Standards over and above NF unit	
	On-call access to mental health provider 24/7	
	Psychosocial rehab staff Rehab staff to client ratio: 1 to 7	
	Overnight awake staff: Meet NF regulations plus ability to provide psychiatric invention	
	Staffing has documented training in skills to care for population including rehabilitation skill development, behavioral management, de-escalation technique and responding to emergency and crisis situations	
	Staff training must be approved by the Department and specific to delivery of ISS and related mental health services.	
Hours of Operation	24/7	
Consumer Need	Meets nursing facility level of care	
	DSM (current version) Serious mental illness characterized to lead to chronic disability	
	Ability to respond to therapeutic interventions	
	Do not require specialized services, i.e. inpatient psychiatric services	
	Does NOT have primary dementia diagnosis	
	History of failed nursing home stays	
	High level of aggression in need of active intervention	
	Reduction in need for intensive, inpatient mental health services	
	Reduction in psychiatric and behavioral symptoms	
	Achievement of behavioral level permitting return to regular nursing facility unit	
Consumer Outcome	Improved or maintained functioning in daily living skills	
	Decreased frequency and duration of hospitalization and inpatient psychiatric services	
Rate:	Nebraska Medicaid NF contracted rate	

Utilization Guidelines

INTERMEDIATE SPECIALIZED SERVICES (ISS)

ADMISSION GUIDELINES

All of the following guidelines are necessary:

1. Diagnosis of a serious mental illness, as defined in NAC Title 471, Chapter 12-004.05 (non-dementia).
2. Has been identified through the Level II Preadmission Screening Process (PASAR) evaluation as meeting nursing facility functional criteria and needing services to maintain or improve their behavioral or functional levels, but not at a specialized services level provided in an Institute for Mental Disease (IMD), an inpatient psychiatric facility or a crisis unit.
3. Based on demonstrated functional and interpersonal skills, requires intensive interventions, monitoring and supervision, which are not available or are unable to be provided a nursing facility, without ISS.
4. Exhibits aggressive or impulsive behavior, which requires frequent intervention, in order to maintain safety of individual and others.
5. Exhibits difficulty in judgment leading to an inability to recognize personal danger or significant inappropriate behavior.
6. Has history of multiple hospitalizations or unsuccessful placements in nursing facilities, as a result of symptoms of the mental illness and associated behavioral manifestations.
7. Other strategies, including behavioral, environmental or chemical interventions, have been repeatedly unsuccessful.
8. Failure to meet criteria for nursing home placement due to psychiatric needs.
9. Low to minimal risk of self harm.

AND Must meet at least one of the following guidelines:

1. Exhibits significant difficulty interacting with others, leading to repeated and unresolvable interpersonal conflicts or severe social isolation.
2. Experiences significant interference with functional ability and daily activities, due to ongoing and unmanageable symptoms of mental illness, including hallucinations or delusions.
3. Exhibits difficulty in making judgments regarding the safety of self and others.
4. Requires ongoing behavioral health services, which are not available or unable to be provided at a nursing facility, with a concurrent acute or short-term need for nursing facility level of care.

EXCLUSIONARY GUIDELINES

Any of the following are sufficient for exclusion from this level of care:

1. The individual's psychiatric condition is of such severity that it can only be safely treated in an acute or subacute inpatient setting.
2. The individual's medical condition is such that it cannot be safely treated in any setting other than a medical hospital.
3. The individual can be safely maintained and effectively treated at a less intensive level of care.
4. The individual has not met PASRR and ISS evaluation.
5. The individual has a primary diagnosis of dementia.
6. The individual is not 21 years of age or older.
7. Need for continuous 1:1 observation in order to maintain safety.
8. The need for use of restraint or seclusion within the last 14 days.
9. Predatory sexual behavior or history of sex offenses.
10. History of persistent physical violence against others or self.
11. History of persistent elopement attempts from psychiatric inpatient level of care.
12. At high risk for suicidal behavior as determined by psychiatrist.

CONTINUED STAY GUIDELINES

All of the following are necessary for continuing treatment at this level of care:

1. Condition continues to meet admission guidelines.
2. Treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. Care is rendered in a clinically appropriate manner and focused on behavioral and functional outcomes as described in the comprehensive care plan.
4. Treatment is individualized and appropriate to the consumer's changing condition with realistic and specific goals for this level of care.
5. All intervention, stabilization, treatment and rehabilitation services are specifically and carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.

6. Appropriate psychopharmacological intervention has been prescribed and/or evaluated.
7. There is documented active discharge and behavioral management and crisis prevention planning.

DISCHARGE GUIDELINES

Any of the following may be sufficient for discharge from this level of care:

1. Documented comprehensive care plan goals and objectives have been substantially met.
2. The individual no longer meets continued stay guidelines or meets guidelines for a less or more intensive level of care.
3. Consent for treatment is withdrawn and it has been determined that the individual has the capacity to make an informed decision.
4. Marked or significant improvement in functional level and/or psychiatric condition warranting transition to a lesser level of care or less restrictive setting, i.e. regular nursing facility.

General Discharge requirements:

- ISS is intended as a level of care and services that is only one component of a continuum of care.
- When the need for a discharge from ISS is indicated, a safe and orderly discharge plan must be developed by the ISS provider, in concert with the individual and any legally responsible or involved parties or support systems. The discharge plan must allow sufficient time and preparation for the transition from one setting to another to occur in a safe, orderly and smooth manner. It must include plans for discharge to a setting where care and services will be provided that will meet the needs of the individual and take into account the preferences of the individual.
- There may also be times when an emergency discharge from ISS is necessary, during situations where the safety, health or well being of the individual or others in the facility is imminently imperiled and appropriate in-house services are not available. At these times, the individual will be discharged, as soon as safe and orderly arrangements can be made for admission to another facility that can appropriately and safely meet the needs of the individual.

**BEHAVIORAL HEALTH
AND MEDICAID MANAGED CARE**

Adult Substance Abuse

ASAM LEVELS of Care and PLACEMENT CRITERIA

Initial Adult Substance Abuse Assessment

Clinical Assessment and Placement Summary

Level I: Outpatient (Individual, Family, Group and Community Support)

Level II.1: Intensive Outpatient

Level II.5: Partial Hospitalization (Partial Care)

Level III.1: Clinically Managed Low Intensity Residential (Halfway House)

Level III.3: Clinically Managed Medium Intensity Residential
(Intermediate Residential, Therapeutic Community)

Level III.5: Clinically Managed High Intensity Residential (Short Term Residential, Dual Disorder Residential – III.5 Enhanced)

Level III.7: Medically Monitored Intensive Inpatient Services
(Inpatient/Hospital – currently not available in Nebraska)

Level II.D: Ambulatory Detoxification

Level III.2D: Clinically Monitored Residential Detoxification (Social Detox)

Level III.7D: Medically Monitored Inpatient Detoxification

Opioid Maintenance Therapy

INITIAL ADULT SUBSTANCE ABUSE ASSESSMENT

- The following is based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 281-312 for the complete criteria.
- The Initial Adult Substance Abuse Assessment must be completed in a licensed Nebraska Substance Abuse Treatment Center, by a fully licensed clinician. Provisionally licensed individuals may not independently conduct any part of the Initial Adult Substance Abuse Assessment.

SCREENING INSTRUMENTS AND SCORES:

All Initial Adult Substance Abuse Assessment Reports must include the use AND results of at least one of the following nationally accepted screening instruments. The instruments may be electronically scored if indicated acceptable by author:

- SASSI (Substance Abuse Subtle Screening Inventory)
- TII (Treatment Intervention Inventory)
- SUDDS (Substance Use Disorder Diagnostic Schedule)
- MADIS (Michigan Alcohol Drug Inventory Screen)
- MAST (Michigan Alcoholism Screening Test)
- MINI (Mini International Neuropsychiatric Interview)
- WPI (Western Personality Interview)
- PBI (Problem Behavior Inventory)
- RAATE (Recovery Attitude and Treatment Evaluator)
- CIWA (Clinical Institute Withdrawal Assessment)

COMPREHENSIVE BIOPSYCHOSOCIAL ASSESSMENT/SUBSTANCE ABUSE EVALUATION:

The ASI (Addiction Severity Index) is required to be used as a face-to-face structured interview guide, to be scored and utilized to provide information for the biopsychosocial assessment/substance abuse evaluation and the multidimensional risk profile.

The biopsychosocial assessment/substance abuse evaluation will include all of the following:

DEMOGRAPHICS

1. Identify provider name, address, phone, fax, and e-mail contact information.
2. Identify client name, identifier, and other demographic information of the client that is relevant.

PRESENTING PROBLEM / CHIEF COMPLAINT

1. External leverage to seek evaluation
2. When was client first recommended to obtain an evaluation
3. Synopsis of what led client to schedule this evaluation

MEDICAL HISTORY

WORK / SCHOOL / MILITARY HISTORY

ALCOHOL & DRUG HISTORY SUMMARY

1. Frequency and amount
2. Drug & alcohol of choice
3. History of all substance use/misuse/abuse
4. Use patterns
5. Consequences of use (physiological, legal, interpersonal, familial, vocational, etc.)
6. Periods of abstinence - when and why
7. Tolerance level
8. Withdrawal history and potential
9. Influence of living situation on use
10. Other addictive behaviors (e.g. problem gambling)
11. IV drug use
12. Prior SA evaluations and findings
13. Prior SA treatment
14. Client's family chemical use history

LEGAL HISTORY *(Information from Criminal Justice System)*

1. Criminal history & other information
2. Drug testing results
3. Simple Screening Instrument Results
4. Risk Assessment Reporting Format for Substance Abusing Offenders Results

FAMILY / SOCIAL / PEER HISTORY

PSYCHIATRIC / BEHAVIORAL HISTORY

1. Previous mental health diagnoses
2. Prior mental health treatment

COLLATERAL INFORMATION (*Family / Friends / Criminal Justice*)

1. Report any information about the client's use history, pattern, and/or consequences learned from other sources.

OTHER DIAGNOSTIC / SCREENING TOOLS—SCORE & RESULTS

CLINICAL IMPRESSIONS

1. Summary of evaluation
 - a. Behavior during evaluation (agitated, mood, cooperation)
 - b. Motivation to change
 - c. Level of denial or defensiveness
 - d. Personal agenda
 - e. Discrepancies of information provided
2. Diagnostic impression (including justification) (may include DSM Axis IV)
3. Strengths Identified (client and family)
4. Problems Identified

RECOMMENDATIONS

1. Complete III. Multidimensional Risk Profile
2. Complete the ASAM Clinical Assessment and Placement Summary

- A comprehensive biopsychosocial assessment can only be obtained through collateral contacts with significant others or family members to gather relevant information about individual and family functioning and through collateral contacts with former and current healthcare providers, friends, and court contacts to verify medical history, substance usage, and legal history.
- When dually credentialed clinicians are completing the evaluation, the recommendations must include co-occurring issues based on the DSM IV diagnosis.
- When LADCs are completing the evaluation, they must include a screening for possible co-occurrence of mental health problems and include referral for mental health evaluation, if appropriate, in their recommendations.

MULTIDIMENSIONAL RISK PROFILE

*Recommendations for individualized treatment, potential services, modalities, resources, and interventions must be based on the ASAM national criteria multidimensional risk profile. Below is a brief overview on how to use the matrix to match the risk profile with type and intensity of service needs. **The provider is responsible for referring to ASAM PPC-2R Pages 281-312 for the full matrix when applying the risk profile for recommendations.***

Step 1: Assess all six dimensions to determine whether the patient has immediate needs related to imminent danger, as indicated by a Risk Rating of “4” in any of the six dimensions. The dimensions with the highest risk rating determine the immediate service needs and placement decision.

Step 2: If the patient is not in imminent danger, determine the patient's Risk Rating in each of the six dimensions. (For patients who have “dual diagnosis” problems, assess Dimensions 4, 5 and 6 separately for the mental and substance-related disorders. This assists in identifying differential mental health and addiction treatment service needs and helps determine the kind of dual diagnosis program most likely to meet the patient's needs.)

Step 3: Identify the appropriate types of services and modalities needed for all dimensions with any clinically significant risk ratings. Not all dimensions may have sufficient severity to warrant service needs at the time of the assessment.

Step 4: Use the Multidimensional Risk Profile produced by this assessment in Steps 2 and 3 to develop an initial treatment plan and placement recommendation. This is achieved by identifying in which level of care the variety of service needs in all relevant dimensions can effectively and efficiently be provided. The appropriate Intensity of Service, Level of Care and Setting may be the highest Risk Rating across all the dimensions. Consider, however, that the interaction of needs across all dimensions may require more intensive services than the highest Risk Rating alone.

Step 5: Make ongoing decisions about the patient's continued service needs and placement by repeating Steps 1 through 4. Keep in mind that movement into and through the continuum of care should be a fluid and flexible processes that is driven by continuous monitoring of the patient's changing Multidimensional Risk Profile.

CLINICAL ASSESSMENT AND PLACEMENT SUMMARY

The Revised Second Edition of the ASAM Patient Placement Criteria: Updating and Using the ASAM PPC-2R

David Mee-Lee, M.D.

CLINICAL ASSESSMENT AND PLACEMENT SUMMARY

Page 1 of 2

Name: _____

Date: _____

Immediate Need Profile: Assessor considers each dimension and with just sufficient data to assess immediate needs. Check "yes" or "no" in the following table:

DIMENSION	QUESTIONS	Yes	No
1. Acute Intoxication and/or Withdrawal potential	1 (a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal?		
1. as above	1 (b) Currently having similar withdrawal symptoms?		
2. Biomedical Conditions or Complications	2. Any current severe physical health problems?		
3. Emotional/Behavioral or Cognitive Conditions or Complications	3 (a) Imminent danger of harming self or others?		
3. as above	3 (b) Unable to function and safely care for self?		

Yes to questions 1a, 1b, 2 and/or 3a or 3b requires that the client immediately be referred for medical and/or mental health evaluation, depending on which dimension(s) involved.

4. Readiness to Change (Treatment acceptance/resistance)	4 (a) Does client appear to need alcohol or other drug treatment / recovery, but is ambivalent or feels it unnecessary? E.g. severe addiction, but client feels controlled use still OK.		
4. as above	4 (b) Client been coerced, mandated or required to have assessment and/or treatment.		

Yes to questions 4a and/or 4b alone, requires staff to begin immediate intervention and motivational strategies appropriate to client's stage of readiness to change.

5. Relapse/Continued Use	5 (a) Is client currently under the influence or intoxicated?		
5. as above	5 (b) Is client likely to continue use of alcohol and/or other drugs, or to relapse, in an imminently dangerous manner?		

Yes to question 5a requires client be considered for withdrawal potential. Yes to question 5a and/or 5b, individual may need to be considered for 24 hour structure or care.

6. Recovery Environment	6. Are there any dangerous family, sig.others, living/work or school situations threatening client's safety, immediate well-being, and/or sobriety?		
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Yes to Dimension 6, without any Yes to questions 1,2 and/or 3, requires that the client be assessed for the need of a safe or supervised environment.

Level of Functioning / Severity: Using assessment protocols that address all 6 dimensions, assign a severity rating of High, Medium or Low for each domain that best reflects the clients functioning and severity. Place a check mark in the appropriate box for each dimension.

Level of Functioning / Severity	Intensity of Service Need	1. Intox With	2. Bio - med	3. Emot Behav	4. Read - iness	5. Rel - apse	6. Rec. Envir
Low Severity - Minimal current difficulty or impairment. Absent, minimal or mild signs and symptoms. Acute or chronic problems mostly stabilized or soon able to be stabilized and functioning restored with minimal difficulty.	Low - No immediate service(s) or low intensity of services needed for this Dimension. Treatment strategies usually able to be delivered in outpatient setting.						
Medium Severity - Moderate difficulty or impairment. Moderate to serious signs and symptoms. Difficulty coping or understanding, but able to function with clinical and other support services and assistance.	Medium - Moderate intensity of service(s), skills training, or supports needed for this Dimension. Treatment strategies may require intensive levels of outpatient care.						
High Severity - Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate & cope with problems.	High - High intensity of service(s), skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings, or closely monitored case management/support services at frequency greater than daily.						

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The Revised Second Edition of the ASAM Patient Placement Criteria: Updating and Using the ASAM PPC-2R

David Mee-Lee, M.D.

CLINICAL ASSESSMENT AND PLACEMENT SUMMARY (conti)

Page 2 of 2

Name: _____

Date: _____

PLACEMENT DECISIONS: Indicate for each dimension, the least intensive level of consistent with sound clinical judgment, based on the client's functioning / severity and service needs.

ASAM PPC-2R Level of Detoxification Service	Level	Dimension 1 Intoxic/Withdrawal	Dimension				
			2. Bio - med	3. Emot Behav	4. Read - iness	5. Rel-apse	6. Rec. Envir
Ambul. Detox without extended on-site	I-D						
Ambul. Detox with extended on-site monitoring	II-D						
Clinically-Managed residential detoxification (Social Detox)	III-2-D						
Medically-monitoring CD Inpatient Detoxification	III-7-D						
Medically-Managed Intensive Inpatient Detoxification	IV-D						
ASAM PPC-2r Level of Care for Other Treatment and Recovery Services *	Level						
Early Intervention / Prevention	0.5						
Outpatient Services/ Individual (Specify Community Support)	I						
Intensive Outpatient Treatment (IOP)	II.1						
Partial Hospitalization (Partial Care)	II.5						
Clinically-Managed Low Intensity Residential Svcs. (Halfway House)	III.1						
Clinically-Managed Medium Intensity Residential (Therapeutic Community, Intermediate Residential)	III.3						
Clinically-Managed High Intensity Residential (Short Term Res, Dual Disorder Res (Enhanced High Intensity)	III.5						
Medically-Monitored Intensive Inpatient	III.7						
Medically-Managed Intensive Inpatient Services	IV						
Opiod Maintenance Therapy (Methadone)	OMT						

PLACEMENT SUMMARY

Level of Care / Service Indicated - Insert the ASAM Level number that offers the most appropriate level of care / service that can provide the service intensity needed to address the client's current functioning / severity.	
Level of Care / Service Received - ASAM Level number - If the most appropriate level is or service is not utilized, insert the most appropriate placement available and circle the Reason for Difference between Indicated and Received Level.	
Reason for Difference - Circle only ONE number - 1. Service Not Available. 2. Provider judgment. 3. Client preference. 4. Client is on wait list for appropriate level / service. 5. Service available, but no payment source. 6. Geographic accessibility. 7. Family responsibility. 8. Language. 9. Not Applicable. 10. Not listed.	

COMMENTS:

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Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
Service Name	OUTPATIENT - SA (Non-residential)
Setting	ASAM LEVEL I
Facility license	Any appropriate setting that meets state licensure or certification criteria
Basic definition	Substance Abuse Treatment Center, Mental Health Center Provision of professionally directed evaluation, treatment, and recovery services for persons experiencing a wide range of substance abuse problems that cause moderate and/or acute disruptions in the individual's life. Such services are provided in regularly scheduled sessions of fewer than 9 contact hours a week. Services are goal oriented interactions with the individual or in group settings. Comprehensive biopsychosocial strengths-based assessment and substance abuse evaluation
Services	Individual/Family/Group counseling Individualized treatment plan within 14 days identifying short and long term goals for reducing or eliminating at-risk behavior Discharge plan begins at admission Relapse prevention plan part of discharge plan Adjunctive services include information gathering, reporting, coordination of services, referral facilitation and collateral contacts. Adjunctive services are limited to individuals who are not also admitted to community support services.
Programming	Consultation and/or referral on general medical, psychiatric and psychopharmacology (dual capable). Monitoring stabilized co-occurring mental health problems Therapies include: motivational enhancement, individual/family/group counseling, educational groups, relapse prevention. Scheduled sessions of fewer than 9 (nine) contact hours per week Evaluations and treatment must integrate strengths & needs Treatment and Discharge plans must be specific, individualized Treatment plan reviews every 30 days
Length of Stay	Varies with severity of illness or response to treatment, generally 3 months
Staffing	Appropriately credentialed treatment professionals. BH purchased services from LADAC's, PLADACs
Staff to Client Ratio	Individual: 1 to 1, Groups: 1:8 staff to client
Hours of Operation	Normal business hours with weekend and evening hours available to consumers
Consumer Need	DSM (current version) for substance related disorder including substance use and substance induced disorder Mental health disorder, if present, is stabilized so as to enable participation. Meets criteria in all six ASAM dimensions: not in withdrawal or can be safely managed, biomedically stable, psychiatric symptoms stable, willing to participate and attend AND assessed for readiness for change, able to achieve and maintain abstinence and related recovery goals with support. No risk of harm to self or others Meets ASAM risk profile
Consumer Outcome	Precipitating condition and relapse potential stabilized such that condition can be managed with less professional structure Low need for professional structure Low risk of relapse Substantially Achieved goals articulated in individualized treatment plan Relapse prevention plan is in place Formal and informal supports have been established Goals not met and treatment at another level of care of more or less intensity indicated
Rate	BH: See Behavioral Health rate schedule NMMCP: See Medicaid rate schedule

LEVEL I: OUTPATIENT TREATMENT SERVICE DEFINITION

- The following is based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 45-53 for the complete criteria. Community Support services require substance dependence diagnoses.

SERVICES: Level I Outpatient Treatment services are organized services which may be delivered in any appropriate community setting that is licensed in Nebraska as a Substance Abuse Treatment Center. While the services follow a defined set of policies and procedures or clinical protocols, they must be tailored to each patient's individual level of clinical severity and must be designed to help the patient achieve changes in his or her alcohol or other drug using behaviors. Treatment must address major lifestyle, attitudinal and behavior issues that may undermine treatment goals or impair the individual's ability to function in at least one life area.

Level I services are appropriate in the following situations:

- As an initial level of care when the severity of the illness warrants this intensity of intervention. Treatment should be able to be completed at this level, thus using only one level of care unless an unanticipated event warrants a reassessment of the appropriateness of this level of care.
- As a "step down" from a more intensive level of care.
- As an alternative approach to engage the resistant individual in treatment, who is in the early stages of change and who is not yet ready to commit to full recovery. This often proves more effective than intensive levels of care that lead to increased conflict, passive compliance, or leaving treatment. If this approach proves successful, the patient may no longer require a higher intensity of service, or may be able to better use such service.

Specific to Nebraska Medicaid and Behavioral Health, there are currently five treatment modalities within Level I. these include:

- Individual Therapy with the client and a provisionally licensed/licensed substance abuse or mental health professional.
- Group Therapy including the client and a provisionally licensed/licensed substance abuse or mental health professional in a group setting of no more than 8 participants. Staff to client ratio not to exceed 1:8.
- Family therapy, with or without the client, performed by a provisionally licensed/licensed substance abuse or mental health professional.
- Community Support which provides and develops the necessary services and supports which enable consumers to live successfully in the (See specific requirements) Staff to client ratio not to exceed 1:25.

HOURS: Individual and Group Therapy Services are provided in regularly scheduled sessions of fewer than nine contact hours per week. Community Support Services are flexible to meet the client's individual needs.

STAFFING: Staffed by appropriately licensed treatment professionals, including addiction-credentialed physicians, psychologists, and others who are able to assess and treat substance-related disorders. Staff must be able to assess the patient's biopsychosocial needs, be knowledgeable about the biopsychosocial dimensions of alcohol and other drug disorders, and assess the patient's readiness to change. Staff must also be capable of monitoring stabilized mental health disorders and recognizing any instability of patients with co-occurring mental health concerns to make appropriate referrals. Refer to specific Community Support staffing requirements under separate cover. Community Support can be provided by para-professional staff who have received specific training relative to chemical dependency and recovery.

THERAPIES: Offered therapies may include individual and group counseling, psychotherapy, motivational enhancement, opium substitution therapy, family therapy, and other therapies in conjunction with the rehabilitation plan, such as educational groups, occupational and recreational therapy, or other therapy. Motivational enhancement and engagement strategies are used in preference to confrontational approaches. Mental health issues, psychotropic medication concerns and their relationship to substance use disorders are addressed as the need arises.

ASSESSMENT/TREATMENT PLAN: The assessment and treatment plan review include an individual biopsychosocial assessment of each patient and an individualized treatment plan, which involves problem formation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. The plan is developed in collaboration with the patient and reflects the patient's personal goals. The initial individualized treatment plan is to be developed within 2 weeks following admission to program with regular reviews every 30 days thereafter. Community support ensures the completion of a comprehensive support and recovery needs assessment with the development of an integrated (see specific service definition for detail).

LENGTH OF STAY: Individualized according to severity of illness and patient's response to treatment and recovery support service.

DOCUMENTATION: Documentation standards include individualized progress notes in the patient's record that clearly reflect implementation of the treatment plan and the patient's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. Documentation reflects ASAM Adult Patient Placement Criteria.

SUPPORT SYSTEMS: Outpatient treatment programs must have emergency services available by telephone 24 hours a day, 7 days a week; medical, psychiatric, psychological, laboratory and toxicology services, which are available on-site or through consultation or referral; medical and psychiatric consultation that are available within 24 hours by telephone or, if in person, within a time frame appropriate to the severity and urgency of the consultation requested. Outpatient treatment programs must also have direct affiliation with, or close coordination through referral to, more intensive levels of care and medication management.

DUAL DIAGNOSIS CAPABLE PROGRAMS: At level I, the patient may have a co-occurring mental disorder that meets the stability criteria for a Dual Diagnosis Capable program. Other patients may have difficulties in mood, behavior or cognition as a result of other psychiatric or substance-induced disorders, or the patient's emotional, behavioral or cognitive symptoms are troublesome but not sufficient to meet the criteria for a diagnosed mental disorder. Patients in these programs may require the kinds of assessment and treatment plan review offered by Dual Diagnosis Enhanced programs, but at a reduced level of frequency and comprehensiveness, because their mental health problems are more stable.

DUAL DIAGNOSIS ENHANCED PROGRAMS: The patient who is identified as in need of Level I Dual Diagnosis Enhanced program services is assessed as meeting the diagnostic criteria for a Mental Disorder as well as a Substance Disorder as defined in the current DSM-IV. Level I Dual Diagnosis enhanced programs offer ongoing intensive case management for highly crisis-prone dually diagnosed individuals. Such services are delivered by cross-trained interdisciplinary staff through mobile outreach and engagement-oriented psychiatric and substance disorders programming. Staff of Level I Dual Diagnosis enhanced programs include credentialed mental health trained staff who are able to assess, monitor and manage severe and persistent mental disorders seen in a Level I setting, as well as other psychiatric disorders that are mildly unstable. Such staff are knowledgeable about the management of co-occurring mental and substance-related disorders, including assessment of the patient's stage of readiness to change and engagement of patients who have co-occurring mental disorders. Level I Dual Diagnosis Enhanced programs must also provide a review of the patient's recent psychiatric history and a mental status examination, reviewed by a psychiatrist, if necessary. A comprehensive psychiatric history and examination and a psycho diagnostic assessment are performed within a reasonable time, as determined by the patient's psychiatric condition. Active reassessment of the patient's mental status and follow-through with mental health treatment and psychotropic medication must be provided and documented at each visit.

DIAGNOSTIC ADMISSION CRITERIA:

- The individual who is appropriately placed in a Level I program is assessed as meeting the diagnostic criteria for a Substance-Related Disorder (including Substance Use Disorder or Substance-Induced Disorder), as defined in the current DSM-IV as well as the dimensional criteria for admission.
- The individual who is identified as in need of Level I Dual Diagnosis Enhanced program services is assessed as meeting the diagnostic criteria for a Mental Disorder as well as a Substance Use Disorder, as defined in the current DSM-IV as well as the dimensional criteria for admission.
- Continued stay is determined by reassessment of criteria and response to treatment.
- The individual is assessed as meeting specifications in ALL of the following six dimensions.
- The following six dimensions and criteria are abbreviated. **Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 45-53 for the complete criteria.**

Dimension 1: Acute Intoxication &/or Withdrawal Potential: Not experiencing withdrawal/minimal risk of severe withdrawal.

Dimension 2: Biomedical Conditions & Complications: None or very stable or receiving concurrent medical monitoring.

Dimension 3: Emotional, Behavioral or Cognitive Conditions & Complications: None or very stable or receiving mental health monitoring.

Dimension 4: Readiness to Change: Ready for recovery but needs motivation and monitoring strategies to strengthen readiness. OR High severity in this dimension but not in other dimensions. Needs a Level I motivational enhancement program.

Dimension 5: Relapse. Cont. Use or Cont. Problem Potential: Able to maintain abstinence or control use and pursue recovery or motivational goals with minimal support.

Dimension 6: Recovery Environment: Recovery environment is not supportive but, with structure and support, the client can cope. For Community Support, consumer must have a substance dependence diagnosis.

Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
Service Name	COMMUNITY SUPPORT - SA (Non-residential)
<i>Setting</i>	ASAM LEVEL I
<i>Facility license</i>	Community-based, most frequently provided in community locations or client's home consistent with individual consumer need. Not facility based
<i>Basic definition</i>	Rehabilitative and support service for persons with primary Axis I substance dependence. Skilled paraprofessionals provide direct rehabilitation and support services and interventions and assist in developing services and supports necessary to maintain abstinence, stable community living, prevention of relapse and admission to higher levels of care. Provided to consumers who are not in a residential setting. Generally requires daily to weekly contact to maintain adequate level of functioning. May be utilized as stand-alone service or supplement to non-residential treatment services. Comprehensive biopsychosocial and strengths based substance abuse needs assessment within 30 days
	Collect information and develop Individual Program/Service Plan within 30 days. Service plan will include specific methods/interventions to address consumer needs as identified on assessment
<i>Services</i>	Individual service plan includes crisis/relapse prevention plan. ISP shall include methods/interventions to address consumer strengths and needs in areas of relapse prevention, interpersonal skills, education, budgeting and independent living skills. Participation in and reporting to treatment team (if engaged in other services) on the progress in areas of relapse prevention, substance use/abuse, application of education & skills, recovery environment (areas identified in plan). Service Coordination and case management activities including coordination or assistance in accessing medical, social, education, housing, transportation, or other appropriate support services as well as linkage to more/less intensive community services. Participation in and reporting to treatment team (if engaged in other services) on the progress in areas of relapse prevention, application of education & skills, recovery environment (areas identified in plan) Crisis/relapse prevention plan Support and intervention in times of crisis. Crisis/relapse intervention and involvement to transition consumer's return to community and avoid need for higher level of care. Monitor and document progress and contacts Facilitates communication between treatment providers Consumer/family education and support
	Ongoing assessment Treatment, rehabilitation and program/service plan meetings Program/service plan reviewed/updated every 30 days Frequency of face to face contacts based upon need - estimate minimum of 3 / month Access to CS worker for support, intervention, coordination during times of crisis. 24/7 access to respond or intervene to real / potential crisis Clinical supervision of individual service plans Service delivery NOT provided during same service delivery hour of other outpatient services Approved service provision, as transition, 30 days post-admission or 30 days pre-discharge from inpatient/residential LOC to decrease length of stay, expedite discharge and support continuum of care Consultation by professionals licensed/credentialed by HHS on general medical, psychopharmacology, psychological issues
<i>Length of Stay</i>	Average 8 months or as long as medically necessary
<i>Staffing</i>	Direct care workers: Minimum staff qualifications of Bachelor's degree or post high school course work in psychology, social work, sociology, and/or other related fields, with specific training relative to chemical dependency and recovery; two years experience in the delivery of substance abuse services or other related human service programs; plus demonstrated skills and competencies to work with consumers with substance use Completion of the staff training curriculum for initial orientation and continuing education Clinical supervision by licensed alcohol and drug counselor or licensed clinician with three to five years experience in the delivery of substance abuse recovery services
<i>Staff to Client Ratio</i>	Caseload 1:25
<i>Hours of Operation</i>	24/7. Access to service during weekend/evening hours or in time of crisis. Directly provide or otherwise demonstrate consumer has on-call access to SA provider 24/7.
<i>Consumer Need</i>	DSM (current version) of substance dependence and meets criteria in all six dimensions High risk of relapse without external supports, unstable recovery living environment Moderate to high need for external supportive structure in relapse prevention. Requires active skill development and interventions. Moderate to high need for external supportive structure in two of three functional areas: vocational/education, social skills, activities of daily living. Medically and psychiatrically stable
<i>Consumer Outcome</i>	Precipitating condition and relapse potential stabilized such that condition can be managed without paraprofessional external supports and interventions Service plan goals in primary problem areas substantially met
<i>Rate</i>	Crisis/relapse prevention plan implemented BH: See Behavioral Health rate schedule NMMCP: See Medicaid rate schedule 1 unit = 1 month

Service Definitions		
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)		
INTENSIVE OUTPATIENT - SA (Non-residential)		ASAM LEVEL II,1
Service Name	Facility based	
Setting	Substance Abuse Treatment Center	
Facility license	Provides group focused, non-residential, intensive, structured outpatient programming consisting primarily of counseling and education about substance related and mental health problems. Services are goal oriented interactions with the individual or in group settings. Provides essential education and treatment services while allowing consumers to apply skills in "real world" environments.	
Basic definition	Comprehensive biopsychosocial strengths-based assessment and substance abuse evaluation	
Services	Treatment plan within 14 days	
	Discharge plan is specific and begins at admission	
	Crisis / Relapse prevention plan	
	Individual/family/group counseling	
	Educational groups	
Programming	Other services could include 24 hour crisis management, family education, self-help group and support group orientation	
	Consultation by professionals licensed/credentialed by HHS on general medical, psychiatric and psychopharmacology	
	Minimum of 10 hours per week of skilled treatment services provided 3-5 times per week.	
	Therapies include: individual and group counseling, medication management, educational groups, motivational enhancement and engagement strategies, family counseling	
	Monitoring stabilized mental health problems	
Length of Stay	Individualized treatment plan reviewed every 14 days	
	Average is 6-10 weeks	
	BH funded programs must have a minimum of 50% licensed alcohol and drug counselors providing direct additions counseling.	
Staffing	Appropriately credentialed treatment professionals (including licensed alcohol and drug counselors, addiction-credentialed physicians, psychologists, mental health and social workers).	
Staff to Client Ratio	1:1 individual, Group 1:12.	
Hours of Operation	Program may be available 7 days/week, during the day, before or after work or school with evening and weekend hours available.	
	DSM (current version) for substance related disorder including substance use and substance induced disorder	
	No signs/symptoms of withdrawal or withdrawal needs can be safely managed	
	Biomedically and psychiatrically stable or being addressed so as to not interfere with treatment	
	Emotional/Behavioral or Cognitive conditions: none or not a distraction from treatment. Problems are manageable at this level. Requires this amount of structured therapy and professional intervention because motivational interventions at lesser level of care have failed OR requires intensity of interventions to promote change - client willing to participate	
Consumer Need	Readiness for change: ambivalent or follow through poor or requires such intensity to improve awareness	
	Relapse, continued use potential unstable, experiencing intensification of symptoms	
	Recovery environment permits continued exposure and consumer lacks skills to maintain adequate functioning or abstinence without intensity of contact, or client lacks social contacts or has contacts that jeopardize recovery.	
	Risk profile: not in imminent danger	
	Treatment plan goals substantially met	
Consumer Outcome	Client can maintain at lesser level of care	
	Crisis/relapse prevention plan implemented	
Rate	BH: See Behavioral Health rate schedule	Minimum 2 hours/day for a minimum of 3 days /week. Consumer maximum is 5 days/week.
	NMMCP: See Medicaid rate schedule	1 unit = 1 consumer hour

LEVEL II.1: INTENSIVE OUTPATIENT TREATMENT SERVICE DEFINITION

- The following is based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance- Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 57-69 for the complete criteria.

SERVICES: Intensive outpatient services may be delivered in any appropriate community setting that meets state licensure requirements in Nebraska as a Substance Abuse Treatment Center. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures or clinical protocols. The service also provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care. Level II programs provide essential education and treatment services while allowing patients to apply their newly acquired skills in “real world” environments.

Services are provided a minimum of 10 hours per week at a minimum of 3 to 5 times per week. Minimum direct staff to client ratio of 1:8 with therapist to client ratio of 1:12 required. (See specific service definition)

HOURS: Intensive Outpatient Programs (IOPs) provide a minimum of 10 hours per week of skilled treatment services provided 3 to 5 times per week, including weekend availability.

STAFFING: Staffed by an interdisciplinary team of appropriately credentialed addiction treatment professionals, including addiction-experienced physicians, who assess and treat substance-related disorders. Program staff are able to obtain and interpret information regarding the patient’s biopsychosocial needs. Some, if not all, program staff have had sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and their interactions with substance related disorders.

THERAPIES: Therapies offered by Level II.1 programs include:

- A minimum of 10 hours per week of skilled, structured treatment services. Services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy. Services are provided in amounts, frequencies and intensities appropriate to the objectives of the individualized treatment plan.
- Family therapy, which involves family members, guardians or significant others in the assessment, treatment and continuing care of the patient.
- A planned format of therapies delivered on an individual and group basis and adapted to the patient’s developmental stage and comprehension level.
- Motivational enhancement and engagement strategies, which are used in preference to confrontational approaches.

ASSESSMENT/TREATMENT PLAN REVIEW: In Level II.1 programs, the assessment and treatment plan review include:

- A comprehensive substance use history, obtained as part of the initial assessment and reviewed by a physician, if necessary.
- A physical examination, as determined by the patient’s medical condition and needs, and program standards. An individual biopsychosocial assessment.
- An individualized treatment plan, including problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. The plan is developed and reviewed in consultation with the patient and reflects the patient’s personal goals. The initial plan must be complete within 2 weeks of admission and the treatment plan must be reviewed every 30 days thereafter.

LENGTH OF STAY: The duration of treatment varies with the severity of the patient’s illness and his or her response to treatment. Average length of stay is 6 to 10 weeks.

DOCUMENTATION: Documentation standards for Level II.1 programs include individualized progress notes in the patient’s record that clearly reflect implementation of the treatment plan and the patient’s response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.

SUPPORT SERVICES: Level II.1 treatment programs have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services. Beyond the essential services, many Level

II.1 programs provide psychopharmacological assessment and treatment and have the capacity to effectively treat patients who have complex co-occurring mental and substance-related disorders. In addition, the programs have active affiliation with other levels of care and can help the patient access support services such as childcare, vocational training and transportation.

DUAL DIAGNOSIS CAPABLE PROGRAMS: The above identified therapies and supports are typically offered by Dual Diagnosis Capable programs to patients with co-occurring addictive and mental disorders who are able to tolerate and benefit from a planned program of therapies. In addition to the standards previously listed, Dual Diagnosis Capable programs document the patient's mental health problems, the relationship between the mental and substance-related disorders, and the patient's current level of mental functioning.

DUAL DIAGNOSIS ENHANCED PROGRAMS: Dual Diagnosis Enhanced Programs are responsible for all of the requirements of the Level II.1 Intensive Outpatient Program in addition to those specific to meet the needs of the patient with mental illness. In addition to the above mentioned support systems, which encompass Dual Diagnosis Capable programs, Level II.1 Dual Diagnosis Enhanced programs offer psychiatric services appropriate to the patient's mental health condition. Such services are available by telephone and on site, or closely coordinated off site, within a shorter time than in a Dual Diagnosis Capable program. Dual Diagnosis Enhanced programs are staffed by appropriately credentialed mental health professionals, who assess and treat co-occurring mental disorders, in addition to the interdisciplinary team of addiction treatment professionals. Some patients, especially those who are severely and persistently mentally ill, may not be able to benefit from a full program of therapies consistent with Intensive Outpatient Level II.1, and thus may require Dual Diagnosis enhanced program services that constitute the intensity of hours in Level II.1, but involve intensive case management, assertive community treatment, medication management, and psychotherapy, as well as substance-abuse treatment services. Dual Diagnosis Enhanced programs provide a review of the patient's recent psychiatric history and a mental status examination (which are reviewed by a psychiatrist, if necessary). A comprehensive psychiatric history and examination and a psycho diagnostic assessment are performed within a reasonable time frame, as determined by the patient's psychiatric condition. Required documentation includes the patient's mental health problems, the relationship between the mental and substance-related disorders, and the patient's current level of mental functioning.

DIAGNOSTIC ADMISSION CRITERIA:

- The patient who is appropriately placed in a Level II.1 program for substance abuse treatment is assessed as meeting the diagnostic criteria for a Substance-Related Disorder (including Substance Use Disorder or Substance-Induced Disorder), as defined in the current DSM-IV.
- The patient in need of Level II.1 Dual Diagnosis Enhanced program services is assessed as meeting the diagnostic criteria for a Mental Disorder as well as a substance-Related disorder, as defined in the current DSM-IV.
- Continued stay is determined by reassessment of admission criteria and response to treatment.
- Direct **admission** to a Level II.1 program is advisable for the patient who meets specifications in Dimension 2 (if any biomedical conditions or problems exist) and in Dimension 3 (if any emotional, behavioral or cognitive conditions or problems exist), as well as in **one** of Dimensions 4, 5, or 6.
- **Transfer** to a Level II.1 program is advisable for the patient who **(a)** has met the essential treatment objectives at a more intensive level of care **and (b)** requires the intensity of services provided at Level II.1 in at least one dimension.
- A patient also may be transferred to Level II.1 from a Level I program when the services provided at Level I have proved insufficient to address the patient's needs or when Level I services have consisted of motivational interventions to prepare the patient for participation in a more intensive level of service, for which he or she now meets the admission criteria.
- The following six dimensions and criteria are abbreviated. ***Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL (pages 57-69) for the complete criteria.***

Dimension 1: Acute Intoxication &/or Withdrawal Potential: Minimal risk of severe withdrawal.

Dimension 2: Biomedical Conditions & Complications: None or not a distraction from treatment. Such problems are manageable at Level II.1.

Dimension 3: Emotional, Behavioral or Cognitive conditions & Complications: Mild severity, w/potential to distract from recovery; needs monitoring.

Dimension 4: Readiness to change: Has variable engagement in treatment, ambivalence, or lack of awareness of the substance use or mental health problem, and requires a structured program several times a week to promote progress through the stages of change.

Dimension 5: Relapse, Cont. Use or Cont. Problem Potential: Intensification of addiction or mental health symptoms indicate a high likelihood of relapse or continued use or continued problems without close monitoring and support several times a week.

Dimension 6: Recovery Environment: Recovery environment is not supportive but, with structure and support, the client can cope.

Service Definitions		
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)		
Service Name	PARTIAL CARE - SA (Non-residential)	ASAM LEVEL II.5
Setting	Facility based	
Facility license	Substance Abuse Treatment Center	
Basic definition	Provides group focused, non-residential, intensive, structured outpatient programming consisting primarily of counseling and education about substance related and mental health problems. Services are goal oriented interactions with the individual or in group settings. Provided to persons who are able to function in a school, work and home setting but are in need of treatment services beyond traditional outpatient programs.	
Services	Comprehensive biopsychosocial strengths-based assessment and substance abuse evaluation	
	Discharge plan begins at admission	
	Crisis / Relapse prevention plan	
	Individual/family/group counseling	
	Educational groups	
Programming	Other services could include 24 hour crisis management, family education, self-help group and support group orientation	
	Consultation by professionals licensed/credentialed by HHS on general medical, psychiatric and psychopharmacology	
	Minimum of 30 hours per week of skilled treatment services per week including a minimum of 15 hours of individual/family or group counseling for each client.	
	Therapies include: individual and group counseling, medication management, educational groups, motivational enhancement and engagement strategies, family counseling	
	Monitoring stabilized mental health problems	
Length of Stay	Initial plan within 24 hours of admission. Individualized treatment plan within 14 days and reviewed every 7 days thereafter.	
	6-8 weeks	
Staffing	BH funded PC programs must have a minimum of 50% licensed alcohol and drug counselors providing direct addictions counseling.	
	Appropriately credentialed treatment professionals (including licensed alcohol and drug counselors, addiction-credentialed physicians, psychologists, mental health and social workers).	
Staff to Client Ratio	Individual 1:1 Group 1:7	
Hours of Operation	During the day, before or after work or school with evening and weekend hours available.	
Consumer Need	DSM (current version) Axis I for substance related disorder including substance use and substance induced disorder	
	Moderate risk of severe withdrawal	
	Biomedically and psychiatrically stable or being addressed so as to not interfere with treatment	
	Emotional/Behavioral or Cognitive conditions: Mild to moderate severity, with potential to distract from recovery; needs stabilization.	
	Readiness for change: Poor engagement in treatment, significant ambivalence, or lack of awareness of the substance use problem, and requires a near daily structured program or intensive engagement services to promote progress through the stages of change.	
Consumer Outcome	Relapse, Cont.Use Potential: intensification of addiction symptoms, despite active participation in lesser intensive service, high relapse or continued use potential without near-daily monitoring and support.	
	Recovery environment is not supportive but, with structure and support and relief from the home environment, the client can cope.	
	Risk profile: not in imminent danger	
	Treatment plan goals substantially met	
	Client can maintain at lesser level of care	
Rate	Crisis/relapse prevention plan implemented	
	BH: See Behavioral Health rate schedule	NMMCP: See Medicaid rate schedule 1 unit = 1 day

LEVEL II.5 PARTIAL HOSPITALIZATION / PARTIAL CARE

- The following is based on the Adult Criteria of the Patient Placement criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT Manual Pages 57-69 for the complete criteria.

SERVICES: Partial Hospitalization services may be delivered in an appropriately licensed Nebraska Substance Abuse Treatment Center in a community setting such as a mental health center, substance abuse center or hospital setting. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. Partial Hospitalization provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care, and can provide essential education and treatment services while allowing patients to apply their newly acquired skills in “real world” environments.

Specific to Nebraska Medicaid, there are currently no existing treatment modalities in Level II.5. In Partial Hospitalization, the required minimum direct care staff ratio is 1:3. Minimum therapist to patient ratio is 1:8. Specific to Nebraska Behavioral Health, Partial Care treatment modality meets the requirements of Level II.5, minimum staff counselor to client ratio is 1:7. (See specific service definition)

HOURS: Partial Hospitalization programs are required to provide a minimum of 20 or more hours per week of clinically intensive programming, as specified in the patient’s treatment plan. Partial Care services are required to provide 30 hours per week of structured activities.

STAFFING: Staff includes an interdisciplinary team of appropriately credentialed addiction treatment professionals; including physicians, who are trained to assess and treat substance-related disorders. Program staff are able to obtain and interpret information regarding the patient’s biopsychosocial needs. Some, if not all, program staff have had sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and their interactions with substance related disorders.

THERAPIES: Therapies offered by Level II.5 programs include:

- A minimum of 20 hours per week of skilled, structured treatment services. Services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy. Services are provided in amounts, frequencies and intensities appropriate to the objectives of the individualized treatment plan.
- Family therapy, which involves family members, guardians or significant others in the assessment, treatment and continuing care of the patient.
- A planned format of therapies delivered on an individual and group basis and adapted to the patient’s developmental stage and comprehension level.
- Motivational enhancement and engagement strategies, which are used in preference to confrontational approaches.

ASSESSMENT/TREATMENT PLAN REVIEW: In Level II.5 programs, the assessment and treatment plan review include:

- A comprehensive substance use history, obtained as part of the initial assessment and reviewed by a physician, if necessary.
- A physical examination, as determined by the patient’s medical condition and needs, and program standards.
- An individual biopsychosocial assessment.
- An individualized treatment plan, including problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. The plan is developed and reviewed in consultation with the patient and reflects the patient’s personal goals. The initial plan must be complete within 24 hours of admission and the treatment plan must be reviewed in consultation with the patient every 7 days thereafter.

LENGTH OF STAY: The duration of treatment varies with the severity of the patient’s illness and his or her response to treatment.

DOCUMENTATION: Documentation standards for Level II.5 programs include individualized progress notes in the patient’s record that clearly reflect implementation of the treatment plan and the patient’s response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.

SUPPORT SYSTEMS: Level II.5 treatment programs typically have direct access to psychiatric, medical and laboratory services, and are therefore better able than Level II.1 programs to meet needs identified in Dimensions 1, 2, and 3, which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting. Patients who meet Level III criteria in Dimensions 4, 5, or 6 and who otherwise would be placed in a Level III program may be considered for treatment in a Level II.5 program if the patient resides in a facility that provides 24-hour support and structure and that limits access to alcohol and other drugs, such as a correctional facility or other licensed health care facility or a supervised living situation. Necessary support systems for Level II.5 include: Medical, psychological, psychiatric, laboratory and toxicology services available on-site or through consultation or referral, psychiatric and medical consultation available within 8 hours by telephone and within 48 hours in person, emergency services available 24 hours a day, 7 days a week, and direct affiliation with (or documented coordination through referral to) more and less intensive levels of care and supportive housing services. Beyond the essential services, many Level II.5 programs provide psychopharmacological assessment and treatment and have the capacity to effectively treat patients who have complex co-occurring mental and substance-related disorders. In addition, the programs have active affiliation with other levels of care and can help the patient access support services such as child care, vocational training and transportation.

DUAL DIAGNOSIS CAPABLE PROGRAMS: The above identified therapies and supports are typically offered by Dual Diagnosis Capable programs to patients with co-occurring addictive and mental disorders who are able to tolerate and benefit from a planned program of therapies. In addition to the standards previously listed, Dual Diagnosis Capable programs document the patient's mental health problems, the relationship between the mental and substance-related disorders, and the patient's current level of mental functioning.

DUAL DIAGNOSIS ENHANCED PROGRAMS: Dual Diagnosis Enhanced Programs are responsible for all of the requirements of the Level II.5 Intensive Outpatient Program in addition to those specific to meet the needs of the patient with mental illness. In addition to the above mentioned support systems, which encompass Dual Diagnosis Capable programs, Level II.5 Dual Diagnosis Enhanced programs offer psychiatric services appropriate to the patient's mental health condition. Such services are available by telephone and on site, or closely coordinated off site, within a shorter time than in a Dual Diagnosis Capable program. Dual Diagnosis Enhanced programs are staffed by appropriately credentialed mental health professionals, who assess and treat co-occurring mental disorders, in addition to the interdisciplinary team of addiction treatment professionals. Some patients, especially those who are severely and persistently mentally ill, may not be able to benefit from a full program of therapies consistent with Intensive Outpatient Level II.5, and thus may require Dual Diagnosis enhanced program services that constitute the intensity of hours in Level II.5, but involve intensive case management, assertive community treatment, medication management, and psychotherapy, as well as substance-abuse treatment services. Dual Diagnosis Enhanced programs provide a review of the patient's recent psychiatric history and a mental status examination (which are reviewed by a psychiatrist, if necessary). A comprehensive psychiatric history and examination and a psycho diagnostic assessment are performed within a reasonable time frame, as determined by the patient's psychiatric condition. Required documentation includes the patient's mental health problems, the relationship between the mental and substance-related disorders, and the patient's current level of mental functioning.

DIAGNOSTIC ADMISSION CRITERIA:

- The patient who is appropriately placed in a Level II.5 program for substance abuse treatment is assessed as meeting the diagnostic criteria for a Substance-Related Disorder (including Substance Use Disorder or Substance-Induced Disorder), as defined in the current DSM-IV.
- The patient in need of Level II.5 Dual Diagnosis Enhanced program services is assessed as meeting the diagnostic criteria for a Mental Disorder as well as a Substance-Related disorder, as defined in the current DSM-IV.
- Continued stay is determined by reassessment of admission criteria and response to treatment.
- Direct **admission** to a Level II.5 program is advisable for the patient who meets specifications in Dimension 2 (if any biomedical conditions or problems exist) and in Dimension 3 (if any emotional, behavioral or cognitive conditions or problems exist), as well as in **one** of Dimensions 4, 5, or 6.
- **Transfer** to a Level II.5 program is advisable for the patient who **(a)** has met the essential treatment objectives at a more intensive level of care **and (b)** requires the intensity of services provided at Level II.5 in at least one dimension.
- A patient also may be transferred to Level II.5 from a Level I or a Level II.1 program when the services have provided at the lower level have proved insufficient to address the patient's needs or when those services have consisted of motivational interventions to prepare the patient for participation in a more intensive level of service, for which he or she now meets the admission criteria. .
- The following six dimensions and criteria are abbreviated. ***Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL (pages 57-69) for the complete criteria.***

Dimension 1: Acute Intoxication &/or Withdrawal Potential: Moderate risk of severe withdrawal.

Dimension 2: Biomedical Conditions & Complications: None or not sufficient to distract from treatment. Such problems are manageable at Level II.5.

Dimension 3: Emotional, Behavioral or Cognitive Conditions & Complications: Mild to moderate severity, w/potential to distract from recovery; needs stabilization.

Dimension 4: Readiness to Change: Has poor engagement in treatment, significant ambivalence, or lack of awareness of the substance use or mental health problem, and requires a near-daily structured program or intensive engagement services to promote progress through the stages of change.

Dimension 5: Relapse, Cont. Use or Cont. Problem Potential: Intensification of addiction or mental health symptoms, despite active participation in a Level I or II.1 program, indicates a high likelihood of relapse or continued use or continued problems without near-daily monitoring and support.

Dimension 6: Recovery Environment: Recovery environment is not supportive but, with structure and support and relief from the home environment, the client can cope.

Service Definitions		
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)		
Service Name	HALFWAY HOUSE - SA (Transitional Residential)	ASAM LEVEL III.1
<i>Setting</i>	Facility based	
<i>Facility license</i>	Substance Abuse Treatment Center	
<i>Basic definition</i>	Transitional 24 hour structured supportive living / treatment facility in the community for adults seeking to reintegrate into the community generally after primary treatment. Services provide safe housing, structure and support affording consumers an opportunity to develop and practice their interpersonal and group living skills, strengthen recovery skills and reintegrate into their community, and if/nd or return to school or employment.	
<i>Services</i>	Comprehensive biopsychosocial assessment upon admission, including mental health screening	
	Discharge plan begins at admission	
	Crisis / Relapse prevention plan	
	Individual/family/group counseling	
	Educational groups	
<i>Programming</i>	Other services could include 24 hour crisis management, family education, self-help group and support group orientation	
	Consultation by professionals licensed/credentialed by HHS on general medical, psychiatric and psychopharmacology	
	Minimum of 8 hours per week of treatment and recovery focused services per week	
	Therapies include: individual and group counseling, educational groups, motivational enhancement and engagement strategies, counseling and monitoring to promote successful reintegration in regular, productive daily activity such as work or school or family living.	
	Monitoring stabilized mental health problems	
<i>Length of Stay</i>	Individualized treatment plan within 14 days and reviewed monthly thereafter.	
	6 to 12 months, average 9 months	
	Program Director responsible for clinical supervision	
<i>Staffing</i>	House Manager	
	One or more clinicians with competence in the treatment of addictions are available on-site or by telephone 24/7.	
	LADACs and PLADACs under supervision provide direct addictions counseling	
	Residential tech staff are on-site and preferably on-call overnight. Tech staff shall have a bachelor's degree or post high school degree in addictions, psychology or related fields or 2 years experience in delivery of substance abuse services or related area or demonstrated skill and competency to work with chronic substance dependence.	
	Minimum 1:10 staff ratio during the day. Prefer awake staff overnight. Licensed/certified staff shall be on call at all times.	
<i>Staff to Client Ratio</i>		
<i>Hours of Operation</i>	24 hours per day with a minimum of 8 hours of treatment and recovery focused services per week	
<i>Consumer Need</i>	DSM (current version) Axis I diagnosis of substance dependence disorder	
	No withdrawal risk or minimal or stable withdrawal.	
	Emotional/Behavioral/Cognitive conditions: None or minimal; not distracting to recovery.	
	Readiness to Change: Open to recovery, but needs a structured environment to maintain therapeutic gains.	
	Relapse, Cont. Use potential: Understands relapse but needs structure to maintain therapeutic gains.	
<i>Consumer Outcome</i>	Recovery Environment: Environment is dangerous but recovery is achievable with 24 hour structure.	
	Treatment plan goals substantially met	
	Client can maintain at lesser level of care	
<i>Rate</i>	Crisis/relapse prevention plan implemented	
	BH: See Behavioral Health rate schedule	NMMCP: See Medicaid rate schedule 1 unit = 1 day

LEVEL III.1: CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL TREATMENT

SERVICE DEFINITION

- The following is based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 71-126 for the complete criteria.

SERVICES: Organized treatment services that feature a planned regimen of care in a 24 hour residential setting that is currently licensed in Nebraska as a Substance Abuse Treatment Center. Treatment services adhere to defined policies, procedures and clinical protocols. Services provide housing, or are affiliated with, permanent facilities where patients can reside safely with structure and support and have an opportunity to develop and practice their interpersonal and group living skills, strengthen their recovery skills, reintegrate into the community and possibly family, and find or return to school or employment. The services provided usually include, individual, group and family therapy; medication management and medication education. Mutual/self-help meetings usually are available on site. Some persons require the structure of a Level III.1 program to achieve engagement in treatment. Those who are in the early stages of readiness to change may need to be removed from an unsupportive living environment in order to minimize their continued alcohol or other drug use. Level III.1 programs can also meet the needs of individuals who may not yet acknowledge that they have an alcohol or other drug problem. Such individuals may be living in a recovery environment that is too toxic to permit treatment on an outpatient basis. Because these individuals are at an early stage of readiness to change, they many need monitoring and motivating strategies to prevent deterioration, engage them in treatment and facilitate their progress through the stages of change to recovery. They are appropriately placed in a Level III.1 supportive environment while receiving “discovery” services as opposed to “recovery” services. In every case, the individual should be involved in planning continuing care to support recovery and improve his or her functioning.

*Specific to Nebraska Medicaid and Behavioral Health, the current treatment modality within Level III.1 is: **Halfway House**. The Halfway House programs for adult substance abuse provide transitional residential services for adults seeking to re-integrate into the community. These programs must provide a structured set of activities designed to develop the living skills necessary for an independent life free from substance abuse ousted of a primary residential treatment program. The program must also focus on assisting clients to maintain or access employment as needed. Minimum 1:10 staff ratio during the day, prefer 1:10 awake staff ratio overnight, with an additional staff on-call. See specific service definition.*

HOURS: Hours of operation are 24 hours per day with a minimum of 8 hours of treatment and recovery focused services per week.

STAFFING: This staff should be comprised of clinical staff and allied health professional staff. The Program Director is responsible for Clinical Supervision. One or more clinicians with competence in the treatment of substance dependence disorders are available on-site or by telephone 24 hours a day.

Licensed Alcohol and Drug Counselors provide direct counseling and all clinical staff are knowledgeable about the biological and psychosocial dimensions of substance dependence and mental health disorders and their treatment, and are able to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff have specialized training in behavior management techniques. Allied health professional staff, such as counselor aides or group living workers, are on-site 24 hours a day or as required by licensing regulations. Allied health professionals shall have a bachelor's degree or post HS degree in SA addictions, psychology, or related fields or 2 years experience in delivery of SA services or related area or demonstrated skill and competency to work with consumers with chronic substance dependence.

THERAPIES: Therapies offered by Level III.1 programs include:

- Services designed to improve the resident's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality.
- Planned clinical program activities designed to stabilize and maintain the stability of the resident's substance dependence symptoms and to help him or her develop and apply recovery skills. Activities may include relapse prevention, interpersonal choices and development of a social network supportive of recovery.
- Counseling and clinical monitoring to promote successful initial involvement or reinvolved in regular, productive daily activity, such as work or school and, as indicated, successful reintegration into family living.
- Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the resident's individual treatment plan.
- Motivational enhancement and engagement strategies appropriate to the resident's stage of readiness to change, which are used in preference to confrontational approaches.

- Counseling and clinical monitoring to support successful initial involvement or reinvolved in regular, productive daily activity, such as work or school, and successful reintegration into family living. Health education services also are provided.
- Regular monitoring of the resident's compliance in taking any prescribed medications.
- Services also are provided to the resident's family and significant others, as appropriate.

ASSESSMENT/TREATMENT PLAN: In Level III.1 programs, the assessment and treatment plan review includes:

- An individualized, comprehensive biopsychosocial assessment of the resident's substance dependence disorder, conducted or updated by staff who are knowledgeable about addiction treatment, to confirm the appropriateness of placement at Level III.1 and to help guide the individualized treatment planning process.
- An individualized treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities, designed to achieve those goals. The plan is developed in collaboration with the resident and reflects the resident's personal goals.
- A biopsychosocial assessment, treatment plan and updates that reflect the resident's clinical progress, as reviewed by an interdisciplinary treatment team
- A physical examination performed within a reasonable time, as determined by the resident's medical condition.
- The treatment plan reflects case management conducted by on-site staff; coordination of related addiction treatment, health care, mental health, and social, vocational or housing services (provided concurrently); and the integration of services at this and other levels of care.
- The treatment plan is reviewed in collaboration with the resident every 30 days and documented accordingly.

LENGTH OF STAY: While the duration of treatment varies with the severity of an individual's illness and his or her response to treatment, the length of service in clinically managed Level III.1 programs tend to be longer than in the more intensive medically monitored and medically managed levels of care. Some individuals may enter Level III.1 programs under a court order that specifies their length of stay.

However, treatment professionals have a responsibility to make admission, continued service and discharge decisions based on their own clinical impressions of an individual's assessed need and treatment progress. Thus, if a patient has improved sufficiently to warrant discharge or transfer, the treatment professional has a responsibility to contact the appropriate court and seek to have the court order amended.

DOCUMENTATION: Level III.1 program documentation includes individualized progress notes in the resident's record that clearly reflect implementation of the treatment plan and the resident's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. Initial Treatment Plan must be completed within 7 days after admission and concurrent reviews are conducted in collaboration with the resident and recorded every 30 days.

SUPPORT SYSTEMS: Necessary support systems include: a) telephone or in-person consultation with a physician, psychologist, RN and emergency services available 24 hours a day, 7 days a week, b) direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services (such as intensive outpatient treatment, vocational assessment and placement, literacy training and adult education). c) the program is able to arrange for needed procedures (including indicated laboratory and toxicology services) as appropriate to the severity and urgency of the resident's condition.

DUAL DIAGNOSIS CAPABLE PROGRAMS: Certain residents, may need the kinds of assessment and treatment services described here for Dual Diagnosis Enhanced, but at a reduced level of frequency and comprehensiveness to match the greater stability of the resident's mental health problems. For such resident's placement in a Dual Diagnosis Capable program may be appropriate.

DUAL DIAGNOSIS ENHANCED PROGRAMS: In addition to the above support systems, Level III.1 Dual Diagnosis Enhanced programs offer psychiatric services, medication evaluation and laboratory services. Such services are provided on-site or closely coordinated off-site, as appropriate to the severity and urgency of the resident's mental condition.

In addition to the staff listed above, Dual Diagnosis Enhanced programs are staffed by appropriately credentialed mental health professionals who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. Some (if not all) of the addiction treatment professionals have had sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and explain to the resident the purposes of psychotropic medications and their interactions with substance use. The intensity of nursing care and observation is sufficient to meet the resident's needs.

The therapies in the Level III.1 Dual Diagnosis Enhanced programs offer planned clinical activities (either directly or through affiliated providers) that are designed to stabilize the resident's mental health problems and psychiatric symptoms and to maintain such stabilization. The goals of therapy apply to both the substance dependence disorder and any co-occurring mental disorder. Specific attention is given to medication education and management and to motivational and engagement strategies which are used in preference to confrontational approaches.

Dual Diagnosis Enhanced programs (either directly or through affiliation with another program) also provide active reassessments of the patient's mental status, at a frequency determined by the urgency of the resident's psychiatric problems, and follow-through with mental health treatment and psychotropic medications. In addition to the assessment and treatment plan review activities described above, Level III.1 Dual Diagnosis Enhanced programs provide a review of the resident's recent psychiatric history and mental status examination, completed by a psychiatrist. A comprehensive psychiatric history and examination and psychodiagnostic assessment are performed within a reasonable time, as determined by the resident's needs.

In addition to the documentation requirements of Level III.1, Dual Diagnosis Enhanced Programs regularly document the resident's mental health problems, the relationship between the mental and substance dependence disorders, and the resident's current level of mental functioning.

DIAGNOSTIC ADMISSION CRITERIA:

- The resident who is appropriately placed in a Level III.1 program meets the diagnostic criteria for a Substance Dependence Disorder, as defined in the current DSM-IV, as well as the dimensional criteria for admission.
- Residents in Level III.1 Dual Diagnosis Capable programs may have co-occurring mental disorders that meet the stability criteria for placement in a Dual Diagnosis Capable program; or difficulties with mood, behavioral or cognition related to a substance use or mental disorder; or emotional, behavioral, or cognitive symptoms that are troublesome but do not meet the DSM-IV criteria for a mental disorder.
- The resident who is appropriately admitted to a Level III.1 Dual Diagnosis Enhanced program meets the diagnostic criteria for a Mental Disorder as well as a Substance Dependence Disorder, as defined in the current DSM-IV, as well as the dimensional criteria for admission.
- The resident who is appropriately admitted to a Level III.1 program meets specifications in each of the six dimensions.
- Continued stay is determined by reassessment of criteria and response to treatment.
- The following six dimensions and criteria are abbreviated. **Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 71-126 for the complete criteria.**

Dimension 1: Acute Intoxication &/or Withdrawal Potential: No withdrawal risk, or minimal or stable withdrawal. Concurrently receiving Level I-D (minimal) or Level II-D (moderate) services.

Dimension 2: Biomedical Conditions & Complications: None or stable, or receiving concurrent medical monitoring.

Dimension 3: Emotional, Behavioral or Cognitive Conditions & Complications: None or minimal; not distracting to recovery. If stable, a Dual Diagnosis Capable program is appropriate. If not, a Dual Diagnosis Enhanced program is required.

Dimension 4: Readiness to Change: Open to recovery, but needs a structured environment to maintain therapeutic gains.

Dimension 5: Relapse, Cont. Use or Cont. Problem Potential: Understands relapse but needs structure to maintain therapeutic gains.

Dimension 6: Recovery Environment: Environment is dangerous but recovery is achievable if Level III.1 24-hour structure is available.

Service Definitions		
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)		
Service Name	INTERMEDIATE RESIDENTIAL - SA (Intermediate Residential)	ASAM LEVEL III.3
<i>Setting</i>	Facility based	
<i>Facility license</i>	Substance Abuse Treatment Center	
<i>Basic definition</i>	Residential treatment for adults with Primary Axis I diagnosis of substance dependence for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of dependence on the individual's life or because of a history of repeated short term or less restrictive treatment failures. Typically more supportive than therapeutic communities and rely less on peer dynamics in treatment approach.	
<i>Services</i>	Comprehensive biopsychosocial assessment upon admission, including mental health screening	
	Discharge plan begins at admission	
	Crisis / Relapse prevention plan	
	Individual/family/group counseling	
<i>Programming</i>	Educational groups	
	Other services could include 24 hour crisis management, family education, self-help group and support group orientation	
	Consultation by professionals licensed/credentialed by HHS on general medical, psychiatric and psychopharmacology	
	30 hours per week of treatment and recovery focused services	
	Programming characterized by slower paced interventions and purposefully repetitive to meet special consumer treatment needs	
	Therapies include: individual and group counseling, educational groups, motivational enhancement and engagement strategies, counseling and monitoring to promote successful reintegration in regular, productive daily activity such as work or school or family living.	
<i>Length of Stay</i>	Monitoring stabilized mental health problems	
	Individualized treatment plan within 14 days and reviewed monthly thereafter.	
	Average 12 months, as long as medically necessary	
	Program Director for clinical supervision, program staff for nursing, recreation, social work and on or more licensed clinicians with competence in addictions treatment	
<i>Staffing</i>	Residential Tech staff shall have a bachelor's degree or post high school degree in addictions, psychology or related fields or 2 years experience in delivery of substance abuse services or related area or demonstrated skill and competency to work with chronic substance dependence.	
	BH funded programs must have a minimum of 50% licensed alcohol and drug counselors providing direct addictions counseling.	
	All clinical staff must be knowledgeable about the biological and psychosocial dimensions of abuse/dependence.	
	Direct care staff ratio of 1:10 days, with 1:10 awake direct care staff overnight. Licensed/certified staff on call at all times.	
<i>Staff to Client Ratio</i>	24/7	
<i>Hours of Operation</i>	DSM (current version) Axis I substance dependence	
	Not at risk of severe withdrawal or moderate withdrawal is manageable	
	Biomedically stable or receiving current medical monitoring	
	Emotional/behavioral/cognitive: mild to moderate severity, needs structure to focus on recovery. Psychiatrically stable.	
	Little awareness or readiness to change. Needs interventions to engage and stay in treatment OR there is high severity in this dimension but not in the others.	
	High risk of relapse and needs structured intervention to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction	
<i>Consumer Need</i>	Recovery environment dangerous. Client requires 24 hour structure to learn to cope.	
	Treatment plan goals substantially met	
	Client can maintain at lesser level of care	
	Crisis/relapse prevention plan implemented	
<i>Rate</i>	BH: See Behavioral Health rate schedule	NMMCP: See Medicaid rate schedule 1 unit = 1 day

LEVEL III.3: CLINICALLY MANAGED MEDIUM-INTENSITY RESIDENTIAL TREATMENT SERVICE DEFINITION

- The following is based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 71-126 for the complete criteria.

SERVICES: Organized treatment services that feature a planned regimen of care in a 24 hour residential setting that is currently licensed in Nebraska as a substance abuse treatment center. Treatment services adhere to defined policies, procedures and clinical protocols. They are housed in, or affiliated with, permanent facilities where patients can reside safely. Level III.3 programs provide structured recovery environment in combination with medium intensity clinical services to support recovery from substance-related disorders. These programs are frequently referred to as extended or long-term care. For the typical resident in a Level III.3 program, the effects of the substance-related disorder on the individual's life are so significant, and the resulting level of impairment so great, that outpatient motivational and/or relapse prevention strategies are not feasible or effective. The functional deficits seen in individuals who are appropriately placed at Level III.3 are primarily cognitive and can be either temporary or permanent. They may result in problems in interpersonal relationships or emotional coping skills. Some individuals have such severe deficits in interpersonal and coping skills that the treatment process is one of "habilitation" rather than "rehabilitation". Treatment of such individuals is directed toward overcoming their lack of awareness of the effects of substance-related problems on their lives, as well as enhancing their readiness to change. Treatment also is focused on preventing relapse, continued problems and/or continued use, and promoting the eventual reintegration of the individual into the community. In every case, the individual should be involved in planning continuing care to support recovery and improve his or her functioning.

Specific to Nebraska Medicaid and Behavioral Health, there are currently two treatment modalities within Level III.3.

Intermediate Residential and Therapeutic Community programs both provide long term comprehensive residential treatment for substance abusing adults for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of the substance abuse on the individual's life or because of a history of repeated treatment failures. These programs must provide psychosocial skill building through a longer-term set of treatment activities with the expectation of a slower progress toward individual change and rehabilitation than is achieved with short-term treatment modalities.

Intermediate Residential programs are typically more supportive than therapeutic communities, and rely less on peer dynamics in their treatment approach. Such services are provided through a longer term set of treatment activities with the expectation of a slower progress toward individual change.

Therapeutic Community programs provide psychosocial skill building through a long term, highly structured set of peer oriented treatment activities which define progress toward individual change and rehabilitation. Client progress is marked by advancement toward accepting personal responsibility.

See service definitions for specific staffing requirements. Minimum requirements include direct care staff ratio of 1:10 during the day, with 1:10 awake direct care staff overnight required for both treatment modalities.

HOURS: Hours of operation are 24 hours per day with 30 hours of treatment and recovery focused services.

STAFFING: Facility staff should be comprised of clinical staff and allied health professional staff. Program Director is responsible for Clinical Supervision. LADC clinical staff provide direct counseling and are knowledgeable about the biological and psychosocial dimensions of substance dependence and mental health disorders and their treatment, and are able to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff have specialized training in behavior management techniques. Allied health professional staff, such as counselor aides or group living workers, are on-site 24 hours a day or as required by licensing regulations. Allied health professionals shall have a bachelor's degree or post HS degree in SA addictions, psychology, or related fields or 2 years experience in delivery of SA services or related area or demonstrated skill and competency to work with consumers with chronic substance dependence. One or more clinicians with competence in the treatment of substance dependence disorders are available on-site or by telephone 24 hours a day.

THERAPIES: Therapies offered by Level III.3 programs include:

- Daily clinical services to improve the resident's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality. Such services are designed to accommodate the cognitive limitations frequently seen in this population.
- Planned clinical program activities designed to stabilize and maintain the stability of the resident's substance dependence symptoms and to help him or her develop and apply recovery skills. Activities may include relapse prevention, interpersonal choices and development of a social network supportive of recovery.
- Counseling and clinical monitoring to promote successful initial involvement or reinvolved in regular, productive daily activity, such as work or school and, as indicated, successful reintegration into family living.
- Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the resident's individual treatment plan.
- Services may involve (but are not limited to) a range of cognitive, behavioral and other therapies administered on an individual and group basis, medication education and management, educational groups, and occupational or recreational activities, and are adapted to the resident's developmental stage and level of comprehension. For residents with significant cognitive deficits, therapies are delivered in a manner that is slower paced, more concrete and more repetitive.
- Regular monitoring of the resident's compliance in taking any prescribed medications.
- Daily scheduled professional addiction and mental health treatment services, designed to develop and apply recovery skills. These may include relapse prevention, interpersonal choices, and development of a social network supportive of recovery from the psychiatric and/or addictive disorder.
- Such services may also include medical services, nursing services, individual and group counseling, family therapy, educational groups, occupational and recreational therapies, art, music or movement therapies, physical therapy, and vocational rehabilitation activities.
- Clinical and didactic motivational interventions appropriate to the resident's stage of readiness to change, and which are designed to facilitate the resident's understanding of the relationship between his or her substance dependence disorder and attendant life issues.
- Services are also provided to the resident's family and significant others.

ASSESSMENT/TREATMENT PLAN: In Level III.3 programs, the assessment and treatment plan review includes:

- An individualized, comprehensive biopsychosocial assessment of the resident's substance dependence disorder, conducted or updated by staff who are knowledgeable about addiction treatment, to confirm the appropriateness of placement at Level III.3 and to help guide the individualized treatment planning process.
- An individualized treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities, designed to achieve those goals. The plan is developed in collaboration with the resident and reflects the resident's personal goals.
- A biopsychosocial assessment, treatment plan and updates that reflect the resident's clinical progress, as reviewed by an interdisciplinary treatment team.
- A physical examination performed within a reasonable time, as determined by the resident's medical condition.
- The treatment plan reflects case management conducted by on-site staff; coordination of related addiction treatment, health care, mental health, and social, vocational or housing services (provided concurrently); and the integration of services at this and other levels of care.

LENGTH OF STAY: While the duration of treatment varies with the severity of an individual's illness and his or her response to treatment, the length of service in clinically managed Level III.3 programs tend to be longer than in the more intensive medically monitored and medically managed levels of care. Some individuals enter Level III programs under a court order that specifies their length of stay.

However, treatment professionals have a responsibility to make admission, continued service and discharge decisions based on their own clinical impressions of an individual's assessed need and treatment progress. Thus, if a patient has improved sufficiently to warrant discharge or transfer, the treatment professional has a responsibility to contact the appropriate court and seek to have the court order amended.

DOCUMENTATION: Level III.3 program documentation includes individualized progress notes in the resident's record that clearly reflect implementation of the treatment plan and the resident's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. Initial treatment plans are developed within 7 days of admission and concurrent treatment plan reviews are conducted with the patient and recorded every 30 days.

SUPPORT SYSTEMS: Necessary support systems include: a) telephone or in-person consultation with a physician, psychologist, RN and emergency services available 24 hours a day, 7 days a week, b) direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services (such as sheltered workshops, and adult education), and c) medical, psychiatric, psychological, laboratory, and toxicology services are available through consultation or referral, as appropriate to the severity and urgency of the resident's condition.

BIOMEDICAL ENHANCED SERVICES: Biomedical Enhanced services are delivered by appropriately credentialed medical staff, who are available to assess and treat co-occurring biomedical disorders and to monitor the resident's administration of medications in accordance with a physician's prescription. The intensity of nursing care and observation is sufficient to meet the patient's needs.

DUAL DIAGNOSIS CAPABLE PROGRAMS: The therapies described above encompass Level III.3 Dual Diagnosis Capable program services for residents who are able to tolerate and benefit from a planned program of therapies.

DUAL DIAGNOSIS ENHANCED PROGRAMS: In addition to the above support systems, Level III.3 Dual Diagnosis Enhanced programs offer psychiatric services, medication evaluation and laboratory services. Such services are available by telephone within 8 hours and on-site or closely coordinated off-site within 24 hours, as appropriate to the severity and urgency of the resident's mental condition.

Dual Diagnosis Enhanced programs are staffed by appropriately credentialed mental health professionals who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. Some (if not all) of the addiction treatment professionals have had sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and explain to the resident the purposes of psychotropic medications and their interactions with substance use. The intensity of nursing care and observation is sufficient to meet the resident's needs. The therapies in the Level III.3 Dual Diagnosis Enhanced programs offer planned clinical activities designed to stabilize the resident's mental health problem and psychiatric symptoms and to maintain such stabilization. The goals of therapy apply to both the substance dependence disorder and any co-occurring mental disorder. Specific attention is given to medication education and management and to motivational and engagement strategies which are used in preference to confrontational approaches. Residents who are severely and persistently mentally ill may not be able to benefit from the therapies described under the Level III.3 program. However, once stabilized such residents will require planning for and integration into intensive case management, medication management and/or psychotherapy. In addition to the documentation requirements of Level III.3, Dual Diagnosis Enhanced Programs document the resident's mental health problems, the relationship between the mental and substance dependence disorders, and the resident's current level of mental functioning.

DIAGNOSTIC ADMISSION CRITERIA:

- The resident who is appropriately placed in a Level III.3 program meets the diagnostic criteria for a Substance Dependence Disorder, as defined in the current DSM-IV, as well as the dimensional criteria for admission.
- Residents in Level III.3 Dual Diagnosis Capable programs may have co-occurring mental disorders that meet the stability criteria for placement in a Dual Diagnosis Capable program: or difficulties with mood, behavioral or cognitive symptoms that are troublesome but do not meet the DSM-IV criteria for a mental disorder.
- The resident who is appropriately admitted to a Level III.3 Dual Diagnosis Enhanced program meets the diagnostic criteria for a Mental Disorder as well as a Substance Dependence Disorder, as defined in the current DSM-IV, as well as the dimensional criteria for admission.
- The resident who is appropriately admitted to a Level III.3 program meets specifications in each of the six dimensions.
- Continued stay is determined by reassessment of criteria and response to treatment.
- The following six dimensions and criteria are abbreviated. **Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 71-126 for the complete criteria.**

Dimension 1: Acute Intoxication &/or Withdrawal Potential: Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level III.2-D.

Dimension 2: Biomedical Conditions & Complications: None or stable, or receiving concurrent medical monitoring.

Dimension 3: Emotional, Behavioral or Cognitive Conditions & Complications: Mild to moderate severity; needs structure to focus on recovery. If stable, a Dual Diagnosis Capable program is appropriate. If not, a Dual Diagnosis Enhanced program is required. Treatment should be designed to respond to the client's cognitive deficits.

Dimension 4: Readiness to Change: Has little awareness and needs interventions available only at Level III.3 to engage and stay in tx; or there is high severity in this dimension but not in others. The client, therefore, needs a Level I motivational enhancement program.

Dimension 5: Relapse, Cont. Use or Cont. Problem Potential: Has little awareness and needs intervention available only at Level III.3 to prevent continued use, with imminent dangerous consequences, because of cognitive deficits or comparable dysfunction.

Dimension 6: Recovery Environment: Environment is dangerous and client needs 24-hour structure to learn to cope.

Service Definitions		
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)		ASAM LEVEL III.3
Service Name	THERAPEUTIC COMMUNITY - SA (Transitional Residential)	
Setting	Facility based	
Facility license	Substance Abuse Treatment Center	
Basic definition	Residential treatment for adults with Primary Axis I diagnosis of substance dependence for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of dependence on the individual's life or because of a history of repeated short term or less restrictive treatment failures. Provides psychosocial skill building through a set of longer term, highly structured set of peer oriented treatment activities which define progress toward individual change and rehabilitation and which incorporate a series of defined phases. Client's progress must be marked by advancement through these phases to less restrictiveness and more personal responsibility.	
Services	Comprehensive biopsychosocial assessment upon admission, including mental health screening	
	Discharge plan begins at admission	
	Crisis / Relapse prevention plan	
	Individual/family/group counseling	
	Educational groups	
	Other services could include 24 hour crisis management, family education, self-help group and support group orientation	
	Consultation by professionals licensed/credentialed by HHS on general medical, psychiatric and psychopharmacology	
	30 hours per week of treatment and recovery focused services	
	Programming characterized peer oriented activities and defined progress through defined phases	
	Therapies include: individual and group counseling, educational groups, motivational enhancement and engagement strategies, counseling and monitoring to promote successful reintegration in regular, productive daily activity such as work or school or family living.	
	Monitoring stabilized mental health problems	
	Individualized treatment plan within 14 days and reviewed monthly thereafter. Progress noted per phase.	
Length of Stay	Average 12 months	
	Program Director for clinical supervision, one or more licensed clinicians with competence in addictions treatment.	
	Residential Tech staff shall have a bachelor's degree or post high school degree in addictions, psychology or related fields or 2 years experience in delivery of substance abuse services or related area or demonstrated skill and competency to work with chronic substance dependence.	
	BH funded programs must have a minimum of 50% licensed alcohol and drug counselors providing direct addictions counseling.	
	All clinical staff must be knowledgeable about the biological and psychosocial dimensions of abuse/dependence.	
	Direct care staff ratio of 1:10 days, with 1:10 awake direct care staff overnight. Licensed/certified staff on call at all times.	
Staff to Client Ratio	24/7	
Hours of Operation	DSM (current version) Axis I substance dependence	
	Not at risk of severe withdrawal or moderate withdrawal is manageable	
	Biomedically stable or receiving current medical monitoring	
	Emotional/behavioral/cognitive: mild to moderate severity, needs structure to focus on recovery. Psychiatrically stable.	
	Little awareness or readiness to change. Needs interventions to engage and stay in treatment OR there is high severity in this dimension but not in the others.	
	High risk of relapse and needs structured intervention to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction	
	Recovery environment dangerous. Client requires 24 hour structure to learn to cope.	
	Treatment plan goals, progress through defined phases substantially met	
	Client can maintain at lesser level of care or successfully transition to community	
Consumer Outcome	Crisis/relapse prevention plan implemented	
Rate	BH: See Behavioral Health rate schedule NMMCP: See Medicaid rate schedule 1 unit = 1 day	

Service Definitions		
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)		
Service Name	SHORT TERM RESIDENTIAL - SA (Transitional Residential)	ASAM LEVEL III.5
Setting	Facility based	
Facility license	Substance Abuse Treatment Center	
Basic definition	Residential program providing highly structured, primary, and comprehensive substance abuse treatment services for individuals who require a more restrictive treatment environment to prevent the use of abused substances.	
	Comprehensive biopsychosocial assessment upon admission, including mental health screening	
	Discharge plan begins at admission	
	Crisis / Relapse prevention plan	
Services	Individual/family/group counseling	
	Educational groups	
	Other services could include 24 hour crisis management, family education, self-help group and support group orientation	
	Consultation by professionals licensed/credentialed by HHS on general medical, psychiatric and psychopharmacology	
	42 hours per week of structured treatment and recovery focused services	
Programming	Establishment of social supports to enhance recovery.	
	Therapies include: individual and group counseling, educational groups, motivational enhancement and engagement strategies, counseling and monitoring to promote successful reintegration. Recreational therapy. Daily clinical services to improve ability to organize tasks of daily living and recovery such as personal responsibility, appearance, prosocial behaviors, stability of recovery.	
	Monitoring stabilized mental health problems	
	Individualized treatment plan within 7 days and reviewed weekly thereafter.	
Length of Stay	Typically 14-45 days. Average Length of Stay is 30 days, as long as medically necessary.	
	Program Director for Clinical Supervision, program staff for nursing, recreation, social work and on or more licensed clinicians with competence in this area.	
Staffing	Residential Tech staff shall have a bachelor's degree or post high school degree in addictions, psychology or related fields or 2 years experience in delivery of substance abuse services or related area or demonstrated skill and competency to work with chronic substance dependence.	
	LMHP/LADAC on staff preferred.	
	BH funded programs must have a minimum of 50% licensed alcohol and drug counselors providing direct addictions counseling.	
	All clinical staff must be knowledgeable about the biological and psychosocial dimensions of abuse/dependence.	
Staff to Client Ratio	Staffing ratio of 1:4 direct service staff day, 1:7 awake overnight staff, 1:7 client per therapist	
Hours of Operation	24/7	
	DSM (current version) Axis I substance dependence	
	Minimal risk of withdrawal	
	Biomedically stable or receiving current medical monitoring	
Consumer Need	Emotional/behavioral/cognitive: repeated inability to control impulses, functional deficits requiring a 24 hour setting to teach coping skills.	
	Readiness to Change: Marked difficulty with, or opposition to treatment, with dangerous consequences or high severity in this dimension but not in others.	
	Relapse, Cont. Use Potential: No recognition of skills needed to prevent continued use, with imminently dangerous consequences.	
	Recovery environment dangerous and client lacks skills to cope outside of a 24 hour structured setting.	
	Treatment plan substantially met	
	Client can maintain at lesser level of care or successfully transition to community	
Consumer Outcome	Crisis/relapse prevention plan implemented	
Rate	BH: See Behavioral Health rate schedule NMMCP: See Medicaid rate schedule 1 unit = 1 day	

LEVEL III.5: CLINICALLY MANAGED HIGH INTENSITY RESIDENTIAL SERVICES

DEFINITION

- The following is based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 71-126 for the complete criteria.

SERVICES: Level III.5 programs are offered in an appropriately licensed Nebraska Substance Abuse Treatment Center. This center may be located in a community setting or a specialty unit within a licensed health care facility. Level III.5 programs are designed to treat persons who have significant social and psychological problems. Such programs are characterized by their reliance on the treatment community as a therapeutic agent. The goals of treatment are to promote abstinence from substance use and antisocial behavior and to effect a global change in participant's lifestyle, attitudes and values. This philosophy views substance-related problem as disorders of the whole person that are reflected in problems with conduct, attitudes, moods, values, and emotional management. The defined characteristics of these residents are found in their emotional, behavioral and cognitive conditions and their living environments.

Individuals who are appropriately placed in a Level III.5 program typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. Their mental disorders may involve serious and persistent mental health issues. Other functional deficits in residents appropriately placed at this level of care include a constellation of criminal history or antisocial behaviors, with a risk of continued criminal behavior, and extensive history of treatment and/or criminal justice involvement, limited education, little or no work history and limited vocational skills. Poor social skills, inadequate anger management skills, extreme impulsivity, emotional immaturity and/or an antisocial value system.

Specific to Nebraska Medicaid and Behavioral Health, the treatment modalities currently available within Level III.5 are Short Term Residential Treatment and Dual Disorder Treatment. The Dual Disorder Treatment is a Dual Diagnosis Enhanced Program. See service specific definitions for detail.

Short Term Residential Treatment provides highly structured 24-hour comprehensive services for substance abusing individuals who require a more restrictive treatment environment to prevent the use of abused substances. Activities of this program must provide a daily structure to prevent access to abused substances must focus on developing knowledge and skills for making lifestyle changes necessary to achieve a life free from substance abuse. Staffing ratio: 1:4 staff during the day; 1:7 staff ratio overnight.

Dual Disorder Treatment is designed to serve persons with co-occurring diagnosis of serious mental illness and substance abuse. The desired outcomes of the Dual Disorder Treatment Program is to stabilize the acute symptoms and to engage the individual to participate in a longer-term program of maintenance, treatment, rehabilitation, and recovery. The individuals served in this program generally present more pervasive with inadequate support systems and have difficulty sustaining involvement with treatment. The dual disorder treatment program provides simultaneous and integrated treatment of co-occurring psychiatric and substance use disorders. This requires a staff composition of dually credentialed staff. Clinical directors must be dually credentialed (LMHP/LADAC). Counselors must be dually credentialed LMHP/LADAC, however, provisional credentialed in one of the two areas is acceptable. The required staff ratio is 1:4 direct service staff, 1:7 awake overnight staff, and 1:7 client per therapist.

HOURS: Hours of operation are 24 hours per day with 42 hours of structured programming.

STAFFING: Program staffing is comprised of clinical staff and allied health professional staff. Program Director is responsible for Clinical Supervision. Clinical staff provide direct counseling and are knowledgeable about the biological and psychosocial dimensions of substance dependence and mental health disorders and their treatment, and are able to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff have specialized training in behavior management techniques. Allied health professional staff, such as counselor aides or group living workers, are on-site 24 hours a day or as required by licensing regulations. Allied health professionals shall have a bachelor's degree or post HS degree in SA addictions, psychology, or related fields or 2 years experience in delivery of SA services or related area or demonstrated skill and competency to work with consumers with chronic substance dependence. One or more clinicians with competence in the treatment of substance dependence disorders are available on-site or by telephone 24 hours a day.

THERAPIES: Therapies offered by Level III.5 programs include:

- Daily clinical services to improve the resident's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality, and to develop and practice prosocial behaviors.
- Planned clinical program activities designed to stabilize and maintain the stability of the resident's substance dependence symptoms and to help him or her develop and apply recovery skills. Activities may include relapse prevention, interpersonal choices and development of a social network supportive of recovery.
- Counseling and clinical monitoring to promote successful initial involvement or reinvolved in regular, productive daily activity, such as work or school and, as indicated, successful reintegration into family living.
- Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the resident's individual treatment plan.
- Services may involve (but are not limited to) a range of cognitive, behavioral and other therapies administered on an individual and group basis, medication education and management, educational groups, and occupational or recreational activities, and are adapted to the resident's developmental stage and level of comprehension.
- Motivational enhancement and engagement strategies appropriate to the resident's stage of readiness to change, which are used in preference to confrontational approaches (except for those residents for whom motivational enhancement strategies would be clinically ineffective).
- Counseling and clinical interventions to teach the resident the skills needed for productive daily activity (such as work or school) and, as indicated, successful reintegration into family living. Health education services also are provided.
- Regular monitoring of the resident's compliance in taking any prescribed medications.
- Planned clinical activities to enhance the resident's understanding of his or her substance dependence and/or mental disorders.
- Daily scheduled professional services, including interdisciplinary assessments and treatment, designed to develop and apply recovery skills. Such services may include relapse prevention, interpersonal choices, and development of a social network supportive of recovery. Such services also may include medical services, nursing services, individual and group counseling, psychotherapy, family therapy, educational groups, occupational and recreation therapies, art, music or movement therapies, physical therapy, and vocational rehabilitation activities.
- Planned community reinforcement designed to foster pro-social values and group living skills.
- Services also are provided to the resident's family and significant others.

ASSESSMENT/TREATMENT PLAN: In Level III.5 programs, the assessment and treatment plan review includes:

- An individualized, comprehensive biopsychosocial assessment of the resident's substance dependence disorder conducted or updated by staff that are knowledgeable about addiction treatment, to confirm the appropriateness of placement at Level III.5 and to help guide the individualized treatment planning process.
- An individualized treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities, designed to achieve those goals. The plan is developed in collaboration with the resident and reflects the resident's personal goals. The initial treatment plan is developed within 24 hours of admission and concurrent reviews are conducted every 7 days.
- A biopsychosocial assessment, treatment plan and updates that reflect the resident's clinical progress, as reviewed by an interdisciplinary treatment team.
- A physical examination performed within a reasonable time, as determined by the resident's medical condition.
- The treatment plan reflects case management conducted by on-site staff; coordination of related addiction treatment, health care, mental health, and social, vocational or housing services (provided concurrently); and the integration of services at this and other levels of care.

LENGTH OF STAY: While the duration of treatment varies with the severity of an individual's illness and his or her response to treatment, the length of service in clinically managed Level III.5 programs tend to be longer than in the more intensive medically monitored and medically managed levels of care. Some individuals enter Level III.5 programs under a court order that specifies their length of stay.

However, treatment professionals have a responsibility to make admission, continued service and discharge decisions based on their own clinical impressions of an individual's assessed need and treatment progress. Thus, if a patient has improved sufficiently to warrant discharge or transfer, the treatment professional has a responsibility to contact the appropriate court and seek to have the court order amended.

DOCUMENTATION: Level III.5 program documentation includes individualized progress notes in the resident's record that clearly reflect implementation of the treatment plan and the resident's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. Treatment plan reviews are recorded appropriately reflecting ASAM Patient Placement Criteria.

SUPPORT SYSTEMS: Necessary support systems include: a) telephone or in-person consultation with a physician, and emergency services available 24 hours a day, 7 days a week. b) direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services (such as vocational assessment and training, literacy training, and adult education), and c) the program is able to arrange for needed medical, psychiatric, psychological, laboratory, and toxicology services are available through consultation or referral, as appropriate to the severity and urgency of the resident's condition.

BIOMEDICAL ENHANCED SERVICES: Biomedical Enhanced services are delivered by appropriately credentialed medical staff, who are available to assess and treat co-occurring biomedical disorders and to monitor the resident's administration of medications in accordance with a physician's prescription. The intensity of nursing care and observation is sufficient to meet the patient's needs.

DUAL DIAGNOSIS CAPABLE PROGRAMS: The therapies described above encompass Level III.5 Dual Diagnosis Capable program services for residents who are able to tolerate and benefit from a planned program of therapies. Certain residents may require the kinds of assessment and treatment services described for Dual Diagnosis Enhanced Services, but at a reduced level of frequency and comprehensiveness to match the greater stability of the residents' mental health problems. For such residents, placement in a Dual Diagnosis Capable program may be appropriate. Other residents, especially those who are severely and persistently mentally ill may not be able to benefit from such a program. Once stabilized, such residents will require planning for and integration into intensive case management, medication management and/or psychotherapy.

DUAL DIAGNOSIS ENHANCED PROGRAMS: In addition to the above support systems, Level III.5 Dual Diagnosis Enhanced programs offer psychiatric services, medication evaluation and laboratory services. Such services are available by telephone within 8 hours and on-site or closely coordinated off-site within 24 hours, as appropriate to the severity and urgency of the resident's mental condition.

Dual Diagnosis Enhanced programs are staffed by appropriately credentialed mental health professionals who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. Some (if not all) of the addiction treatment professionals have had sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and explain to the resident the purposes of psychotropic medications and their interactions with substance use. The intensity of nursing care and observation is sufficient to meet the resident's needs.

The therapies in the Level III.5 Dual Diagnosis Enhanced programs offer planned clinical activities designed to stabilize the resident's mental health problem and psychiatric symptoms and to maintain such stabilization. The goals of therapy apply to both the substance dependence disorder and any co-occurring mental disorder. Specific attention is given to medication education and management and to motivational and engagement strategies which are used in preference to confrontational approaches.

In addition to the assessment requirements of Level III.5, Dual Diagnosis Enhanced Programs provide a review of the resident's recent psychiatric history and mental status examination. A psychiatrist conducts this review. A comprehensive psychiatric history and examination a psychodiagnostic assessment are performed within a reasonable time, as determined by the resident's needs. Dual Diagnosis Enhanced programs also provide active reassessments of the patient's mental status, at a frequency determined by the urgency of the resident's psychiatric problems, and follow-through with mental health treatment and psychotropic medications.

In addition to the documentation requirements described above, the Dual Diagnosis Enhanced programs document the resident's mental health problems, the relationship between the mental and substance dependence disorders, and the resident's current level of mental functioning.

DIAGNOSTIC ADMISSION CRITERIA:

- The resident who is appropriately placed in a Level III.5 program meets the diagnostic criteria for a Substance Dependence Disorder as defined in the current DSM-IV, as well as the dimensional criteria for admission.
- Residents in Level III.5 Dual Diagnosis Capable programs may have co-occurring mental disorders that meet the stability criteria for placement in a Dual Diagnosis Capable program; or difficulties with mood, behavior or cognition related to a substance use or mental disorder; or emotional, behavioral or cognitive symptoms that are troublesome but do not meet the DSM-IV criteria for a mental disorder.
- The resident who is appropriately admitted to a Level III.5 Dual Diagnosis Enhanced program meets the diagnostic criteria for a Mental Disorder as well as a Substance Dependence Disorder, as defined in the current DSM-IV.
- The resident who is appropriately admitted to a Level III.5 program meets specifications in each of the six dimensions.

- Continued stay is determined by reassessment of criteria and response to treatment.
- The following six dimensions and criteria are abbreviated. **Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 71-126 for the complete criteria.**

Dimension 1: Acute Intoxication &/or Withdrawal Potential: At minimal risk of withdrawal, at Levels III.3 or III.5. If withdrawal is present, it meets Level III.2-D criteria.

Dimension 2: Biomedical Conditions & Complications: None or stable, or receiving concurrent medical monitoring.

Dimension 3: Emotional, Behavioral or Cognitive Conditions & Complications: Demonstrates repeated inability to control impulses or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A Dual Diagnosis Enhanced setting is required for SPMI Severely and Persistently Mentally Ill patients.

Dimension 4: Readiness to Change: Has marked difficulty with, or opposition to tx, with dangerous consequences; or there is high severity in this dimension but not in others. The client, therefore, needs a Level I motivational enhancement program.

Dimension 5: Relapse, Cont. Use or Cont. Problem Potential: Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences.

Dimension 6: Recovery Environment: Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting.

Service Definitions		
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)		
Service Name	DUAL DISORDER RESIDENTIAL - SA (Transitional Residential)	ASAM LEVEL III.5 Enhanced
<i>Setting</i>	Facility based	
<i>Facility license</i>	Substance Abuse Treatment Center or specialty unit within a licensed health care facility	
<i>Basic definition</i>	Residential program providing highly structured, primary, and comprehensive substance abuse and mental health treatment services for individuals with co-occurring serious mental illness and substance dependence. Program provides simultaneous and integrated treatment. Program is generally longer term and designed to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery.	
<i>Services</i>	Comprehensive biopsychosocial strengths based assessment upon admission, including mental health screening	
	Discharge plan begins at admission	
	Crisis / Relapse prevention plan	
	Individual/family/group counseling	
	Medication education and management	
<i>Programming</i>	Educational groups	
	Other services could include 24 hour crisis management, family education, self-help group and support group orientation	
	Consultation by professionals licensed/credentialed by HHS on general medical, psychiatric and psychopharmacology	
	42 hours per week of structured treatment and recovery focused services	
	Establishment of social supports to enhance recovery.	
<i>Length of Stay</i>	Therapies include: individual and group counseling, educational groups, motivational enhancement and engagement strategies, counseling and monitoring to promote successful reintegration. Recreational therapy. Daily clinical services to improve ability to organize tasks of daily living and individualized treatment plan within 14 days and reviewed monthly thereafter.	
	Typically 12 months, as long as medically necessary.	
	Program Director for clinical supervision, program staff for nursing, recreation, social work.	
	Residential Tech staff shall have a bachelor's degree or post high school degree in addictions, psychology or related fields or 2 years experience in delivery of substance abuse services or related area or demonstrated skill and competency to work with chronic substance dependence.	
	Dually credentialled : LMHP/LADAC staff.	
<i>Staff to Client Ratio</i> <i>Hours of Operation</i>	All clinical staff must be knowledgeable about the biological and psychosocial dimensions of abuse/dependence.	
	Staffing ratio of 1:4 direct service staff day, 1:7 awake overnight staff, 1:7 client per therapist	
	24/7	
	DSM (current version) Axis I diagnoses of substance dependence and severe and persistent mental illness and meets specifications in all 6 dimensions.	
	Minimal risk of withdrawal	
<i>Consumer Need</i>	Biomedically stable or receiving current medical monitoring	
	Emotional/behavioral/cognitive: repeated inability to control impulses, functional deficits requiring a 24 hour setting to teach coping skills.	
	Readiness to Change: Marked difficulty with, or opposition to treatment, with dangerous consequences or high severity in this dimension but not in others.	
	Relapse, Cont. Use Potential: No recognition of skills needed to prevent continued use, with imminently dangerous consequences.	
	Recovery environment dangerous and client lacks skills to cope outside of a 24 hour structured setting.	
<i>Consumer Outcome</i>	Treatment plan goals substantially met	
	Client can maintain at lesser level of care or successfully transition to community	
	Crisis/relapse prevention plan implemented	
<i>Rate</i>	BH: See Behavioral Health rate schedule NMMCP: See Medicaid rate schedule 1 unit = 1 day	

LEVEL II-D: AMBULATORY DETOXIFICATION WITH EXTENDED ON-SITE MONITORING SERVICE DEFINITION

- The following is based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 145-175 for the complete criteria.

SERVICES: Level II-D: Ambulatory detoxification with extended on-site monitoring is an organized outpatient service, which may be delivered in an office setting, health care, mental, or addiction treatment facility that is currently licensed in Nebraska as a Substance Abuse Treatment Center. Trained clinicians provide medically supervised evaluation, detoxification and referral services. Level II-D services are provided in regularly scheduled sessions. They are delivered under a defined set of policies and procedures or medical protocols. Outpatient services are designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood altering drugs (including alcohol) and to effectively facilitate the patient's entry into ongoing treatment and recovery. Essential to this level of care is the availability of appropriately credentialed and licensed nurses who monitor patients over a period of several hours each day of service.

HOURS: Hours of operation are 24 hours per day.

*Specific to Nebraska Medicaid, there are available treatment modalities statewide that are consistent with this service description without further definition. **Behavioral Health does not contract for this service modality.***

STAFFING: Level II-D detoxification programs are staffed by physicians and nurses, who are essential to this type of service, although they need not be present at all times. Physician assistants or nurse practitioners licensed as physician extenders may perform the duties designated for a physician.

Because Level II-D detoxification is conducted on an outpatient basis, it is important for medical and nursing personnel to be readily available to evaluate and confirm that detoxification in the less supervised setting is relatively safe.

The services of counselors, psychologists and social workers may be available through the detoxification program or may be accessed through affiliation with entities providing other Level II services.

All clinicians who assess and treat patients are able to obtain and interpret information regarding the needs of these persons, and are knowledgeable about the biopsychosocial dimensions of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care.

Medical consultation is readily available in emergencies.

THERAPIES: Therapies offered by Level II-D detoxification programs include individual assessment, medication or non-medication methods of detoxification, involvement of family members or significant other in the detoxification process, and discharge or transfer planning.

- Therapies also may include physician and/or nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal.

ASSESSMENT/TREATMENT PLAN REVIEW: In Level II-D detoxification programs, elements of the assessment and treatment plan review include:

- An addiction-focused history obtained as part of the initial assessment and reviewed by a physician during the admission process.
- A physical examination by a physician, physician assistant, or nurse practitioner within a reasonable time frame as part of the initial assessment.
- Sufficient biopsychosocial screening assessments to determine the level of care in which the patient should be placed for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6.
- An individualized treatment plan, including problem identification in Dimensions 2 through 6 and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives.
- Daily assessment of patient progress through detoxification and any treatment changes.
- Discharge/transfer planning, beginning at admission.
- Referral arrangements, made as needed.

LENGTH OF STAY: The patient continues in a Level II-D detoxification program until withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care;

or

Alternatively, the patient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a more intensive level of detoxification service is indicated;

or

The patient is unable to complete detoxification at Level II-D, despite an adequate trial. For example, he or she is experiencing intense craving and has insufficient coping skills to prevent continued alcohol or other drug use, indicating a need for more intensive services.

DOCUMENTATION: Documentation standards of Level II-D programs include progress notes in the patient's record that clearly reflect implementation of the treatment plan and the patient's response to treatment, as well as subsequent amendments to the plan. Detoxification rating scale tables and flow sheets (which may include tabulation of vital signs) are used as needed.

SUPPORT SYSTEMS: In Level II-D detoxification, support systems feature:

- Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems.
- Ability to obtain a comprehensive medical history and physical examination of the patient at admission.
- Access to psychological and psychiatric consultation.
- Direct affiliation with other levels of care, including other levels of specialty addiction treatment, as well as general and psychiatric services for additional problems identified through a comprehensive biopsychosocial assessment.
- Ability to conduct and/or arrange for appropriate laboratory and toxicology tests.
- 24-hour access to emergency medical services.
- Ability to provide or assist in accessing transportation services for patients who are unable to drive safely for legal or medical reasons, or who otherwise lack transportation.

DIAGNOSTIC ADMISSION CRITERIA:

The patient who is appropriately placed in a Level II-D detoxification program meets the diagnostic criteria for Substance Induced Disorder of the current DSM-IV, as well as the ASAM dimensional criteria for admission. **Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT CRITERIA MANUAL PAGES 145-175.**

The patient who is appropriately placed in a Level II-D detoxification program meets specifications in (a) *and* (b):

- (a) The patient is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent. The patient is assessed as being at moderate risk of severe withdrawal syndrome outside the program setting, is free of severe physical and psychiatric complications, and would safely respond to several hours of monitoring, medication and treatment (see examples pg. 164-169).

AND

- (b) The patient is assessed as likely to complete detoxification and to enter into continued treatment or self-help recovery, as evidenced by meeting [1] and either [2] or [3]:

[1] The patient or support persons clearly understand instructions for care and are able to follow instructions; *and*

[2] The patient has an adequate understanding of ambulatory detoxification and has expressed commitment to enter such a program; *or*

[3] The patient has adequate support services to ensure commitment to completion of detoxification and entry into ongoing treatment or recovery; *or*

[4] The patient evidences willingness to accept a recommendation for treatment once withdrawal has been managed.

Service Definitions		
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)		
Service Name	SOCIAL DETOXIFICATION - SA (Emergency)	ASAM LEVEL III.2D
<i>Setting</i>	Facility based	
<i>Facility license</i>	Substance Abuse Treatment Center	
<i>Basic definition</i>	Social setting emergency detoxification programs provide intervention in substance abuse emergencies on a 24 hour per day basis to individuals experiencing acute intoxication. Such programs must have the capacity to provide a safe residential setting with staff present for observation and delivery of services designed to physiologically restore the individual from an acute state of intoxication. Programs provide care to persons whose condition necessitates observation by qualified personnel but does not necessitate medical treatment. (Clinically managed)	
<i>Services</i>	Comprehensive biopsychosocial strengths based assessment upon admission, including mental health screening Discharge plan begins at admission Crisis / Relapse prevention plan Capacity to assess for medical needs and administration of fluids Education, counseling and referral Consultation by professionals licensed/credentialed by HHS on general medical, psychiatric and psychopharmacology. Establishment of social supports to enhance recovery. Therapies include: individual and group counseling, health education, motivational enhancement and engagement strategies and counseling. Implementation of physician approved protocols Clinical records document assessment, therapies, and monitoring of physical status (detoxification rating scale and monitoring of vital signs)	
<i>Length of Stay</i>	2-5 days	
<i>Staffing</i>	Program Director for clinical supervision Detoxification Tech staff shall have a bachelor's degree or post high school degree in addictions, psychology or related fields or 2 years experience in delivery of substance abuse services or related area. Consultation, i.e. physician, registered nurse, LMHP, psychopharmacology, etc. shall be available and used as needed by staff and/or with consumers All clinical staff must be knowledgeable about the biological and psychosocial dimensions of abuse/dependence.	
<i>Staff to Client Ratio</i>	1 to 8	
<i>Hours of Operation</i>	24/7	
<i>Consumer Need</i>	Experiencing signs and symptoms of withdrawal or there is evidence that withdrawal is imminent. The individual is assessed as not being at risk of severe withdrawal syndrome and moderate withdrawal is safely manageable at this level of service. Individual is assessed as not requiring medication but requires this level of service to complete detoxification and enter into continued treatment or self-help recovery.	
<i>Consumer Outcome</i>	Consumer successfully detoxified and assessed for service/treatment needs. Crisis/relapse prevention plan implemented	
<i>Rate</i>	BH: See Behavioral Health rate schedule NMMCP: See Medicaid rate schedule 1 unit = 1 day	

LEVEL III.2D: CLINICALLY MANAGED RESIDENTIAL DETOXIFICATION

SERVICE DEFINITION

- The following is based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 145-175 for the complete criteria.

SERVICES: Level III.2-D may be conducted in a health care or addiction treatment facility that is currently licensed in Nebraska as a Substance Abuse Treatment Center.

Specific to Nebraska Medicaid and Behavioral Health, there are available treatment modalities statewide that are consistent with this service description. See Social Detoxification service definition.

HOURS: Hours of operation are 24 hours per day.

STAFFING: Level III-2D social detoxification programs are staffed by appropriate credentialed personnel who are trained and competent to implement physician-approved protocols for patient observation and supervision, determination of appropriate level of care, and facilitation of the patient's transition to continuing care.

Level III.2-D social detoxification is a clinically managed detoxification service designed explicitly to safely detoxify patients without the need for ready on-site access to medical and nursing personnel.

Medical evaluation and consultation is available 24 hours a day, in accordance with treatment/transfer practice guidelines.

All clinicians that assess and treat patients are able to obtain and interpret information regarding the needs of these patients. Such knowledge includes the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care.

Facilities that supervise self-administered medications have appropriately licensed or credentialed staff and policies and procedures in accordance with state and federal law.

Staff assure that patients are taking medications according to physician prescription and legal requirements.

THERAPIES: Therapies offered by Level III.2-D detoxification programs include daily clinical services to assess and address the needs of each patient. Such clinical services may include appropriate medical services individual and group therapies, and withdrawal support.

The following therapies are provided as clinically necessary, depending on the patient's progress through detoxification and his or her assessed needs in Dimensions 2 through 6:

- A range of cognitive, behavioral, medical, mental health and other therapies are administered to the patient on an individual or group basis. These are designed to enhance the patient's understanding of addiction, the completion of the detoxification process and referral to an appropriate level of care for continuing treatment.
- Multidisciplinary individualized assessment and treatment.
- Health education services.
- Services to families and significant others.

ASSESSMENT/TREATMENT PLAN REVIEW: In Level III.2-D detoxification programs, elements of the assessment and treatment plan review include:

- An addiction-focused history obtained as part of the initial assessment and review with a physician during the admission process if physician developed protocols indicate concern.
- A physical examination by a physician, physician assistant, or nurse practitioner as part of the initial assessment if self-administered detoxification medications are to be used.
- Sufficient biopsychosocial screening assessments to determine the level of care in which the patient should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6.
- An individualized treatment plan, including problem identification in Dimensions 2 through 6 and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives.
- Daily assessment of patient progress through detoxification and any treatment changes.
- Discharge/transfer planning, beginning at admission.
- Referral arrangements, made as needed.

LENGTH OF STAY: The patient continues in a Level III.2-D detoxification program until withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care;

or

Alternatively, the patient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a more intensive level of detoxification service is indicated;

or

The patient is unable to complete detoxification at Level III.2-D, despite an adequate trial. For example, he or she is experiencing increasing depression and suicidal impulses, complication cocaine withdrawal and indicating the need for transfer to a more intensive level of care or the addition of other clinical services (such as intensive counseling).

DOCUMENTATION: Documentation standards of Level III.2-D programs include progress notes in the patient's record that clearly reflect implementation of the treatment plan and the patient's response to treatment, as well as subsequent amendments to the plan. Detoxification rating scale tables and flow sheets (which may include tabulation of vital signs) are used as needed.

SUPPORT SYSTEMS: In Level III.2-D detoxification, support systems feature:

- Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems.
- Protocols used to determine the nature of the medical interventions required (including nursing and physician care and/or transfer to a medically monitored facility or an acute care hospital) are developed and supported by a physician knowledgeable in addiction medicine.
- Direct affiliation with other levels of care.
- Ability to conduct and/or arrange for appropriate laboratory and toxicology tests.

DIAGNOSTIC ADMISSION CRITERIA:

The patient who is appropriately placed in a Level III.2-D detoxification program meets the diagnostic criteria for Substance Induced Disorder of the current DSM-IV, as well as the ASAM dimensional criteria for admission. **Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT CRITERIA MANUAL PAGES 145-175.**

The patient who is appropriately placed in a Level III.2-D detoxification program meets specifications in (a) *and* (b):

- (c) The patient is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent. The patient is assessed as not being at risk of severe withdrawal syndrome, and moderate withdrawal is safely manageable at this level of service (see examples pg. 164-169).

AND

- (d) The patient is assessed as not requiring medication, but requires this level of service to complete detoxification and enter into continued treatment or self-help recovery because of inadequate home supervision or support structure, as evidenced by meeting [1] or [2] or [3]:

[1] The patient's recovery environment is not supportive of detoxification and entry into treatment, and the patient does not have sufficient coping skills to safely deal with the problems in the recovery environment; *or*

[2] The patient has a recent history of detoxification at less intensive levels of service that is marked by inability to complete detoxification or to enter into continuing addiction treatment, and the patient continues to have insufficient skills to complete detoxification; *or*

[3] The patient has demonstrated an inability to complete detoxification at a less intensive level of services, as by continued use of other-than-prescribed drugs or other mind-altering substances.

LEVEL III-7D: MEDICALLY MONITORED INPATIENT DETOXIFICATION SERVICE DEFINITION

- The following is based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance- Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 145-175 for the complete criteria.

SERVICES: Level III.7D detoxification is an organized service delivered by medical and nursing professionals that provides for 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting that is currently licensed in Nebraska as a Substance Abuse Treatment Center. Services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols.

Level III.7D provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It sometimes is provided by overlapping with Level IV-D services (as a “step-down” service) in a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

Level III.7D services can also be provided by overlapping with Level III.2-D services to encourage the use of 24-hour detoxification and support but utilizing fewer resources. Both services can exist on the same milieu.

*Specific to Nebraska Medicaid, there are available treatment modalities statewide that are consistent with the Level III.7-D service description without further definition. **Behavioral Health does not currently contract for this service.** Nebraska will be exploring the creative use of overlapping levels of detoxification and support for the adult substance abuse client.*

HOURS: Hours of operation are 24 hours per day.

STAFFING: Level III.7-D detoxification programs are staffed by:

- Physicians, who are available 24 hours a day by telephone. (Or a physician assistant or nurse practitioner as licensed as physician extenders may perform duties designated by physician).
- A physician is available to assess the patient within 24 hours of admission (or earlier, if medically necessary), and is available to provide on-site monitoring of care and further evaluation of a daily basis.
- A registered nurse or other licensed and credential nurse is available to conduct a nursing assessment on admission.
- A nurse is responsible for overseeing the monitoring of the patient’s progress and medication administration on an hourly basis, if needed.
- Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders. The level of nursing care is appropriate to the severity of patient needs.
- Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for patients and their families.
- An interdisciplinary team of appropriately trained clinicians such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the patient and to obtain and interpret information regarding the patient’s needs. The number and disciplines of team members are appropriate to the range and severity of the patient’s problems.

THERAPIES: Therapies offered by Level III.7-D detoxification programs include daily clinical services to assess and address the needs of each patient. Such clinical services may include appropriate medical services, individual and group therapies and withdrawal support. Additional therapies may include hourly nurse monitoring of the patient’s progress and medication administration, if needed.

The following therapies are provided as clinically necessary, depending on the patient’s progress through detoxification and the assessed needs in Dimensions 2 through 6:

- A range of cognitive, behavioral, medical, mental health and other therapies are administered to the patient on an individual or group basis. These are designed to enhance the patient’s understanding of addiction, the completion of the detoxification process and referral to an appropriate level of care for continuing treatment.
- Multidisciplinary individualized assessment and treatment.
- Health education services.
- Services to families and significant others.

ASSESSMENTS/TREATMENT PLAN REVIEW: In Level III.7-D detoxification programs, elements of the assessment and treatment plan review include:

- An addiction-focused history obtained as part of the initial assessment and reviewed by a physician during the admission process.
- A physical examination by a physician, physician assistant or nurse practitioner within 24 hours of admission and appropriate laboratory and toxicology tests. If level III.7-D detoxification services are step-down services from Level III.7-D records of a physical examination within the preceding 7 days are evaluated by a physician within 24 hours of admission.
- Sufficient biopsychosocial screening assessments to determine the level of care in which the patient should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6.
- An individualized treatment plan, including problem identification in Dimensions 2 through 6 and development of treatment goals and measurable objectives and activities designed to meet those objectives.
- Daily assessment of patient progress through detoxification and any treatment changes.
- Discharge/transfer planning beginning at admission.
- Referral arrangements, made as needed.

LENGTH OF STAY: The patient continues in a Level III.7-D detoxification program until withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care;

or

Alternately, the patient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a Level IV-D detoxification service is indicated.

DOCUMENTATION: Documentation standards of Level III.7-D programs include progress notes in the patient's record that clearly reflect implementation of the treatment plan and the patient's response to treatment, as well as subsequent amendments to the plan. Detoxification rating scale tables and flow sheets, which may include tabulation of vital signs, are used as needed.

SUPPORT SYSTEMS: In Level III.7-D detoxification, support systems feature:

- Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems.
- Availability of medical and nursing care and observation as warranted based on clinical judgment.
- Direct affiliation with other levels of care.
- Ability to conduct or arrange for appropriate laboratory and toxicology tests.

DIAGNOSTIC ADMISSION CRITERIA:

The patient who is appropriately placed in a Level III.7-D detoxification program meets the diagnostic criteria for Substance Induced Disorder of the DSM-IV, as well as the ASAM dimensional criteria for admission. **Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT CRITERIA MANUAL PAGES 145-175.**

The patient who is appropriately placed in a Level III.7-D detoxification program meets specifications in (a) OR (b):

- (a) The patient is experiencing signs and symptoms of severe withdrawal, or there is evidence, based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional, behavioral, or cognitive condition that a severe withdrawal syndrome is imminent (see examples pages 164-170).

OR

- (b) There is a strong likelihood that the patient who requires medication will not complete detoxification at another level of care and enters into continuing treatment or self help recovery (see examples pages 171-175).

Service Definitions	
BEHAVIORAL HEALTH (BH) & MEDICAID MANAGED CARE (NMMCP)	
Service Name	OPIOID / METHADONE MAINTENANCE THERAPY - SA (Non-residential)
<i>Setting</i>	Facility based
<i>Facility license</i>	Substance Abuse Treatment Center or specialty unit in health care facility
<i>Basic definition</i>	Methadone Maintenance and Detoxification programs provide medical and social services to opiate addicted adults along with outpatient addictions treatment counseling services. The program must provide detoxification and maintenance services with the purpose of rehabilitation from substance abuse/dependence.
<i>Services</i>	Comprehensive biopsychosocial strengths based assessment upon admission, including mental health screening
	Treatment / maintenance plan within 14 days, reviewed monthly. Ability to adjust dosage of methadone daily if needed.
	Discharge plan begins at admission
	Crisis / Relapse prevention plan
	Dispensing of methadone in decreasing doses to alleviate symptoms of withdrawal
<i>Programming</i>	Education and counseling minimum of once per month
	Case management and referral
	Consultation by professionals licensed/credentialed by HHS on general medical, psychiatric and psychopharmacology.
	Continued monitoring of use of methadone with ability to adjust plan daily if needed
	Ability to provide daily methadone dispensing
	Establishment of social supports to enhance recovery.
	Therapies include: individual and group counseling, health education, motivational enhancement and engagement strategies and counseling.
	Programming and services provided under a defined set of policies and procedures stipulated by state and federal statutes and regulations.
	Continued evaluation
	Monitored urine testing
<i>Length of Stay</i>	12 months, as long as medically necessary
<i>Staffing</i>	Program Director for clinical supervision
	On staff or through consultant agreements: Pharmacist for dispensing of medications, physicians, registered nurse
	LADAC, LMHP
<i>Staff to Client Ratio</i>	Case Management
<i>Hours of Operation</i>	1:10
<i>Consumer Need</i>	24/7
	DSM (current version) for Opioid Dependence disorder
	Demonstrate specific objective and subjective signs of opiate dependence, as define by federal regulations
	Physiologically dependent and requires OMT to prevent withdrawal
	Biomedically stable or manageable with outpatient medical services
	Psychiatrically stable
	Ready to chane the negative effects of opiate use but not ready for total abstinence
	High risk of relapse or continued use
	Recovery environment supportive and/or client has skills to cope
	Consumer stabilized on OMT regimen
<i>Consumer Outcome</i>	Treatment plan goals substantially met
	Crisis/relapse prevention plan implemented
<i>Rate</i>	BH: See Behavioral Health rate schedule NMMCP: See Medicaid rate schedule 1 unit = 1 day

OPIOID MAINTENANCE THERAPY SERVICE DEFINITION

- The following is based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R). Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 145-175 for the complete criteria.

SERVICES: Opioid maintenance therapy (OMT) is an organized, usually ambulatory, addiction treatment service for opiate-addicted patients and may be delivered in any community setting that is licensed in Nebraska as a Substance Abuse Treatment Center. “Opioid maintenance therapy” is an umbrella term that encompasses a variety of pharmacological and nonpharmacological treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone and LAAM to psychopharmacologically occupy opiate receptors in the brain, extinguish drug craving and establish a maintenance state. The result is a continuously maintained state of drug tolerance in which the therapeutic agent does not produce euphoria, intoxication or withdrawal symptoms. Treatment with methadone or LAAM is designed to address the patient’s need to achieve changes in his or her level of functioning, including elimination of illicit opiate and other alcohol or drug use. To accomplish such change, the patient’s treatment plan must address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of recovery and inhibit the individual’s ability to cope with major life tasks.

Opioid maintenance therapy is best conceptualized as a separate service that can be provided at any level of care, depending on the patient’s status in Dimensions 1 through 6. Adjunctive nonpharmacologic interventions are essential and may be provided in the clinic or through coordination with another treatment provider.

Opioid maintenance therapy is provided under a defined set of policies and procedures, including admission, discharge and continued service criteria stipulated by state law and regulation and the federal regulations at FDA 21 CFR Part 291. See specific service requirements for Behavioral Health.

STAFFING: Staff of OMT programs include an interdisciplinary team of appropriately trained addiction professionals, including a medical director, counselors and the medical staff delineated as follows:

- Licensed medical, nursing or pharmacy staff, who are available to administer medications in accordance with the physician’s prescriptions or orders. The intensity of nursing care is appropriate to the services provided by an outpatient treatment program that uses methadone or LAAM.
- A physician, who is available during medication dispensing and clinic operating hours, either in person or by telephone.

The interdisciplinary team will also include social workers and licensed psychologists, as needed. Team members must be knowledgeable in the assessment, interpretation, and treatment of the biopsychosocial dimensions of alcohol or other drug dependence. They would receive supervision appropriate to their level of training and experience.

THERAPIES: Therapies offered in OMT programs include:

- Individualized assessment and treatment.
- Medication: Assessing, prescribing, administering, reassessing and regulating dose levels appropriate to the individual; supervising detoxification from opiates, methadone or LAAM; overseeing and facilitating access to appropriate treatment, including medication for other physical and mental health disorders, provided as needed.
- Monitored urine testing.
- Counseling: A range of cognitive, behavioral and other addiction-focused therapies, reflecting a variety of treatment approaches, provided to the patient on an individual, group or family basis.
- Case management: Case management, including medical monitoring and coordination of on- and off-site treatment services, provided as needed. Case managers also assure the provision of, or referral to, educational and vocational counseling, treatment of psychiatric illness, child care, parenting skills development, primary health care and other adjunct services, as needed.
- Psychoeducation, including HIV/AIDS and other health education services.

ASSESSMENT/TREATMENT PLAN REVIEW: In OMT programs, the assessment and treatment plan review includes:

- A comprehensive medical history, physical examination and laboratory tests, provided or obtained in accordance with federal regulations. The tests must be done at the time of admission and reviewed in accordance with federal regulations. The tests must be done at the time of admission and reviewed by a physician as soon as possible, but no later than 14 days after admission {FDA 21 CFR Part 291}.

- An individual biopsychosocial assessment.
- An appropriate regimen of methadone or LAAM (as required by FDA regulation), at a dose established by a physician at the time of admission and monitored carefully until the patient is stable and an adequate dose has been established. The dose then is reviewed as indicated by the patient's course of treatment.
- Continuing evaluation and referral for care of any serious biomedical problems.
- An individualized treatment plan, including problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. The plan is developed in collaboration with the patient and reflects the patient's personal goals. The initial treatment plan is developed within 24 hours of admission with concurrent treatment plan reviews every 30 days thereafter.

LENGTH OF STAY: Duration of treatment varies with the severity of the patient's illness and his or her response to treatment and desire to continue treatment.

DOCUMENTATION: Documentation standards of OMT programs include individualized progress notes in each patient's record for every shift. Such notes clearly reflect implementation of the treatment plan and the patient's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.

Because of special recordkeeping requirements for OMT programs, records also should include documentation of each dose of methadone or LAAM administered, with a copy of the physician's order for methadone or LAAM.

SUPPORT SYSTEMS: In OMT programs, necessary support systems include:

- Linkage with or access to psychological, medical and psychiatric consultation.
- Linkage with or access to emergency medical and psychiatric care through affiliations with more intensive levels of care.
- Linkage with or access to evaluation and ongoing primary medical care.
- Ability to conduct or arrange for appropriate laboratory and toxicology tests
- Availability of physicians to evaluate, prescribe and monitor use of methadone or LAAM, and of nurses and pharmacists to dispense and administer methadone or LAAM.

Ability to provide or assist in arrangements for transportation services for patients who are unable to drive safely or who lack transportation

DIAGNOSTIC ADMISSION CRITERIA:

- The patient who is appropriately placed in opioid maintenance therapy is assessed as meeting the diagnostic criteria for Opioid Dependence disorder, as defined in the current DSM IV, or other standardized and widely accepted criteria aside from those exceptions listed in the *Federal Register* of the U.S. Department of Health and Human Services, Food and Drug Administration, *21 CFR Part 291*.
- Individuals who are admitted to treatment with methadone or LAAM must demonstrate specific objective and subjective signs of opiate dependence, as defined in *FDA 21 CFR Part 291*.
- Continued stay is determined by reassessment of criteria and response to treatment.
- The patient who is appropriately placed in opioid maintenance therapy is assessed as meeting the required specifications in Dimensions 1 through 6.
- The following six dimensions and criteria are abbreviated. **Providers are responsible to refer to the ASAM PPC-2R ADULT PLACEMENT MANUAL Pages 137-143 for the complete criteria.**

Dimension 1: Acute Intoxication &/or Withdrawal Potential: Physiologically dependent on opiates and required OMT to prevent withdrawal.

Dimension 2: Biomedical Conditions & Complications: None or manageable with outpatient medical monitoring.

Dimension 3: Emotional, Behavioral or Cognitive Conditions & Complications: None or manageable in an outpatient structured environment

Dimension 4: Readiness to Change: Ready to change the negative effects of opiate use, but is not ready for total abstinence.

Dimension 5: Relapse, Cont. Use or Cont. Problem Potential: At high risk of relapse or continued use without OMT and structured therapy to promote treatment progress.

Dimension 6: Recovery Environment: Recovery environment is supportive and/or the client has skills to cope.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

Division of Behavioral Health Services
Medicaid Division

Approved by the Policy Cabinet 12/17/2005
FOR DIVISIONS: BEHAVIORAL HEALTH, MEDICAID